



# PROVIDER MANUAL

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## Welcome

Welcome to AmeriHealth Caritas Iowa – a mission-driven managed care organization located in Des Moines, Iowa, serving members of Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (*hawk-i*) programs. By providing unparalleled access, focusing on seamless care coordination, and leveraging the strength and success of current Iowa Department of Human Services (DHS) initiatives, we will drive quality health outcomes for the Medicaid and CHIP populations.

This *Provider Manual* was created to assist you and your office staff with providing services to our members, your patients. As a provider, you agree to use this *Provider Manual* as a reference pertaining to the provision of medical services for members of AmeriHealth Caritas Iowa.

This *Provider Manual* may be changed or updated periodically. AmeriHealth Caritas Iowa will provide you with notice of updates; providers are also responsible to check the Plan's website, [www.amerihealthcaraitasIA.com](http://www.amerihealthcaraitasIA.com) regularly for updates.

Thank you for your participation in the AmeriHealth Caritas Iowa provider network. We look forward to working with you!

## Sharing Our Mission

As our provider partner, we invite you to share our mission: **To help people get care, stay well, and build healthy communities. We have special concern for those who are poor.**

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# **SECTION I GETTING STARTED**

# I. GETTING STARTED

## Who We Are

AmeriHealth Caritas Iowa, Inc. (“AmeriHealth Caritas Iowa” or “the Plan”) is a managed care organization and a member of the AmeriHealth Caritas Family of Companies – an industry leader in the delivery of quality health care to populations covered by publicly funded programs, including Medicaid, Medicare and State Children's Health Insurance programs. We are proud to partner with Iowa to provide health care coverage for enrollees of:

- Iowa Medicaid
- Iowa Health and Wellness Plan
- Healthy and Well Kids (Iowa hawk-i program)

Through our partnership with you – our dedicated providers – we intend to help our members achieve healthy lives and build healthy communities.

## About Our Program

Iowa’s Medicaid programs are administered through the Iowa Department of Human Services (DHS). AmeriHealth Caritas Iowa has been contracted by DHS to provide covered services for enrollees throughout the State of Iowa.

## Plan and DHS Contact Information

### AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa  
P. O. Box 1516  
Des Moines, IA 50305  
1-844-411-0579 (Toll Free)  
Phone 1-515-330-3800  
Fax: 1-844-412-7886  
Monday – Friday, 8:00 am-5:00pmCST

### Iowa Department of Human Services

Iowa Department of Human Services  
P.O. Box 36450  
Des Moines, IA 50315  
1-800-338-7909 (Toll Free)  
515-256-4609 (Des Moines area)  
515-725-1155 (Fax) 8am-5pm CST  
[IMEProviderServices@dhs.state.ia.us](mailto:IMEProviderServices@dhs.state.ia.us). (E-mail)

For a complete listing of important contact information, refer to the Provider Quick Reference Guide found on [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com).

## Member Enrollment

Applicants will be tentatively assigned to a health plan after Medicaid eligibility has been determined, and subsequently will have a 90 day time period in which to choose a different health plan. .

## Accepting AmeriHealth Caritas Iowa Members

AmeriHealth Caritas Iowa expects network Providers to accept all voluntary and assigned members without restriction and in the order in which they enroll. AmeriHealth Caritas Iowa providers will not discriminate on the basis of religion, political beliefs, gender, sexual orientation, marital status, race, color, age, national origin, health status, pre-existing physical or mental condition, or need for health care services and will not use any policy or practice that has the effect of such discrimination.

## Primary Care Selection & Assignment

New AmeriHealth Caritas Iowa members are encouraged to select a Primary Care Provider (PCP). If a PCP is not selected by a member, the Plan will:

- Inform the member of their right to choose a PCP.
- Assist the member in selecting a PCP.
- Inform the member that each eligible family member has the right to choose his/her own PCP.
- Automatically assign a PCP to members who do not proactively choose a PCP within ten days of enrollment with the plan.

The Plan considers the following when assigning a PCP:

- The member's previous PCP (If known and if the provider's capacity and location allows).
- The closest PCP to the member's ZIP code location.
- Children/adolescents within the same family are assigned together.
- Children with special health care needs are assigned to providers with appropriate experience and training.

Once the selection and/or assignment has been made, the AmeriHealth Caritas Iowa Medicaid member's identification (ID) card and selected or assigned PCP name (or group name) will be distributed by mail to the member within seven days of selection or assignment. AmeriHealth Caritas Iowa Medicaid members who were automatically assigned to a PCP and will be notified of the opportunity and procedures to change PCPs.

## Verifying Member Eligibility

AmeriHealth Caritas Iowa member eligibility varies. As a participating provider, you are responsible to verify member eligibility with AmeriHealth Caritas Iowa before rendering services, except when a member requests services for an emergency medical condition.

Eligibility may be verified by:

- Visiting the provider area of AmeriHealth Caritas Iowa's website, [www.amerhealthcaritasIA.com](http://www.amerhealthcaritasIA.com), to access NaviNet, a free, web-based application for electronic transactions and information through a secure multi-payer portal.
- Calling Provider Services at 1-844-411-0579 and following the prompts for Member Eligibility.

- Using AmeriHealth Caritas Iowa's real-time eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system verification, including point of service (POS) devices.
- Asking to see the member's Plan ID card. Members are instructed to keep the ID card with them at all times. The member's ID card includes:
  - The member's name, AmeriHealth Caritas Iowa ID number and Medicaid ID number; and,
  - The Plan's name, address and Member Services telephone number.

**NOTE:** AmeriHealth Caritas Iowa ID cards are not returned to the Plan when a member becomes ineligible. Presentation of an AmeriHealth Caritas Iowa ID card is not proof that an individual is currently a member of AmeriHealth Caritas Iowa. You are encouraged to request a picture ID to verify that the person presenting is the person named on the ID card. If you suspect a non-eligible person is using a member's ID card, please report the occurrence to the Fraud Waste and Abuse Hotline at **1-866-833-9718**.

### **AmeriHealth Caritas Iowa Medicaid Member ID card**

[INSERT IMAGE OF ID CARD]

## Member Rights and Responsibilities

As a Plan provider, it is your responsibility to recognize the following member rights and responsibilities:

### Member Rights

- To be treated with dignity and respect.
- To receive health care in the comfort and convenience of a practitioner or provider office.
- To be sure others cannot hear or see them when they are getting health care.
- To have their health care records remain private, according to HIPAA rules.
- To receive free translation services as needed, including help with sign language, if hearing impaired.
- To participate in making decisions about their own health care, including the right to refuse treatment.
- To receive a full, clear and understandable explanation of treatment/service options and the risks of each option in order to make an informed decision, regardless of cost or benefit coverage.
- Female members have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. Female members have the right to designate as their PCP a participating provider or an advanced practicing registered nurse who specializes in obstetrics (OB) and gynecology (GYN).
- To have access to medical records in accordance with applicable federal and state laws.
- To choose a PCP from AmeriHealth Caritas Iowa's list of providers.
- To change a PCP and choose another one from AmeriHealth Caritas Iowa's list of providers.
- To choose an appropriate participating specialist as a PCP if there is a chronic, disabling, or life threatening medical condition.
- To file a complaint ("grievance") or appeal orally or in writing.
- To receive family planning services and supplies from the provider of choice.
- To be provided good quality care without unnecessary delay.
- To receive information on advance directives and assistance in preparing them; to choose not to have or continue any life-sustaining treatment.
- To receive a copy of the *Member Handbook*.
- To continue in current treatment until a new treatment plan is in place.
- To receive an explanation of prior authorization policies and procedures.
- To be aware of incentive plans for AmeriHealth Caritas Iowa's practitioners and providers.
- To receive a summary of the most recent patient satisfaction survey.
- To receive a copy of AmeriHealth Caritas Iowa's prescription drug formulary.
- To receive a copy of AmeriHealth Caritas Iowa's "Dispense as Written" policy for *prescription* drugs.
- To receive information about AmeriHealth Caritas Iowa, our services, our practitioners and providers and other health care workers, our facilities, and rights and responsibilities as a member.
- To make recommendations about the members' rights and responsibilities.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- To seek a second opinion from a qualified health care professional within the network or out-of-network at no cost.
- To be informed of any cost-sharing obligations (excluding client participation) upon becoming a Plan member and at least 30 days prior to any change.
- To be informed within 10 days of any changes to client participation (patient liability) as determined by Iowa DHS.
- To be informed about how and where to access any benefits that are available under other Iowa programs but are not covered by AmeriHealth Caritas Iowa.
- AmeriHealth Caritas Iowa Medicaid members have the right to receive non-emergency transportation to get health care services 24 hours a day, 365 days a year.

- To be informed regarding the potential obligations of cost for services furnished while an appeal is pending (if the outcome of the appeal is adverse to the member).
- To not be held liable for any debts in the event of AmeriHealth Caritas Iowa's insolvency.
- To request information on the structure of AmeriHealth Caritas Iowa.
- To be treated no differently by providers or by AmeriHealth Caritas Iowa for exercising the rights listed here.
- The right to fully participate in the community and to work live and learn to the fullest extent possible.
- To have access to a full range of primary, acute, specialty services, behavioral health and long term services and supports, as needed, to achieve desired outcomes

### Member Responsibilities

- To treat AmeriHealth Caritas Iowa employees, practitioners and providers with respect.
- To show your Medicaid card each time you visit your health care provider and make sure their office has a record that you on Medicaid.
- To confirm that the provider is enrolled in Medicaid. Medicaid will not pay for the service or prescription of the provider is not a Medicaid provider.
- To comply with the rules of the Iowa DHS and AmeriHealth Caritas Iowa.
- To understand health problems, participate in developing treatment/service goals and to follow the practitioner or provider's instructions for care after deciding what treatment is needed.
- To keep doctor's appointments or call to cancel at least 24 hours in advance.
- To ask questions, discuss personal health issues and listen to what treatment is needed.
- To know the difference between a true emergency and a condition needing urgent care.
- To seek medical services that are medically necessary.
- To know what an emergency is; how to keep emergencies from happening; and what to do if one does happen.
- To help get medical records from past providers.
- To report to AmeriHealth Caritas Iowa if injured in an accident or at work.
- To report to the Iowa DHS and AmeriHealth Caritas Iowa if covered by other health insurance.
- To tell your medical provide, Iowa DHS and AmeriHealth Caritas if anyone else is responsible for paying your medical bills
- To report Medicaid fraud and abuse when suspected. Call the U.S. Department of Health & Human Service at **1-800-447-8477**

### Plan Privacy and Security Procedures

AmeriHealth Caritas Iowa complies with all federal and IME regulations regarding member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information as outlined in 45 CFR Parts 160 & 164. All member health and enrollment information is used, disseminated and stored according to Plan policies and guidelines to ensure its security, confidentiality and proper use. **As an AmeriHealth Caritas Iowa provider, you are expected to be familiar with your responsibilities under HIPAA and to take all necessary actions to fully comply.**



## **SECTION II PROVIDER AND NETWORK INFORMATION**



## II. Provider and Network Information

This section provides information for maintaining network privileges and sets forth expectations and guidelines for Primary Care Providers (PCPs), Specialists and Facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all providers, including behavioral health providers and long term services and supports providers (LTSS).. Additional information pertaining to behavioral health providers and LTSS providers, including specific credentialing and re-credentialing requirements, are also provided in the “Behavioral Health Care” and “LTSS” sections of this *Provider Manual*.

### BECOMING A PLAN PROVIDER

Health care providers are invited to participate in the AmeriHealth Caritas Iowa network based on their qualifications and an assessment and determination of the network's needs. All providers enrolled with AmeriHealth Caritas Iowa must also be enrolled with the Iowa Medicaid Enterprise (IME).

#### Network Provider Types

Primary Care Providers (PCP)s	Family Planning Clinics
Physician Extenders /Nurse practitioners	Maternal and Child Health Centers
Behavioral Health Providers	Urgent Care Clinics
Essential Hospital Services	Other Safety Net Providers and Community Partners
Physician Specialists	Community Based Residential Alternatives
Health Homes	Indian Health Care providers
Federally Qualified Health Centers and Rural Health Clinics	Home and Community Based Services; LTSS providers

### Provider Credentialing and Re-credentialing

AmeriHealth Caritas Iowa is responsible for credentialing and re-credentialing its network of medical or physical health providers. Additional information pertaining to behavioral health providers, and LTSS providers including specific credentialing and re-credentialing requirements are also provided in the “Behavioral Health Care” and “LTSS” sections of this *Provider Manual*.

Hospital-based physicians are not required to be independently credentialed if those providers serve AmeriHealth Caritas Iowa members only through the hospital and those providers are credentialed by the hospitals.

AmeriHealth Caritas Iowa maintains criteria and processes to credential and re-credential the following practitioners:

Medical Doctor (M.D.)	Doctor of Osteopathic Medicine (D.O.)
Doctor of Dental Surgery (D.D.S.)	Doctor of Dental Medicine (D.M.D.)
Doctor of Podiatric Medicine (D.P.M.)	Doctor of Chiropractic (D.C.)
Doctor of Psychology (Psy.D.)	Physical Therapist (P.T.)
Occupational Therapist (O.T.)	Speech Therapist (S.T.)
Advanced Practice Registered Nurse (A.P.R.N.)	Certified Registered Nurse Anesthetist (C.R.N.A.) – if practicing in a free-standing facility
Nurse Practitioner (N.P.)	Physician Assistant (P.A.)
Certified Nurse Midwife (C.N.M.)	Clinical Social Worker (MSW)
Doctor of Audiology (Au. D)	Optometrist (OD)
Optician	

AmeriHealth Caritas Iowa also maintains criteria and processes to credential and re-credential the following provider types:

Hospitals	Home Health Agencies
Skilled Nursing Facilities	Durable Medical Equipment (DME)/Medical Supplies
Dialysis Centers	Hospice
Ambulatory Surgical Centers	Radiology Centers
Maternal Health Center	Behavioral Health Facilities
Rural Health Clinics	Rehabilitative Agency
Nursing Facility/Intermediate Care Facility	Community Mental Health
Family Planning	Residential Care Facility
ICF/ID State	Mental Hospital
Community-Based ICF/ID	Birth Center
Screening Center	Habilitation Services
Maternal & Child Health Center	Psych Medical Inst. Children (PMIC)
ESRD	Lab
Pharmacies	Screening Center

Area Education Agency	Local Education Agency
Early Access Service Coordinator	Habilitation Services
Assertive Community Treatment	Public Health Agency
HCBS - Waiver	

The criteria, verification methodology and processes used by AmeriHealth Caritas Iowa are designed to credential and re-credential practitioners and providers in a non-discriminatory manner, with no attention to race, ethnic/national identity, gender, age, sexual orientation, specialty or procedures performed.

AmeriHealth Caritas Iowa's credentialing/re-credentialing criteria and standards are consistent with State and Federal requirements and National Committee for Quality Assurance (NCQA) requirements. Practitioners are recredentialed and facility/organizational providers are recertified at least every three years.

AmeriHealth Caritas Iowa works with the Council for Affordable Quality Healthcare (CAQH) to offer providers a Universal Provider Data source that simplifies and streamlines the data collection process for credentialing and re-credentialing.

Through CAQH, providers submit credentialing information to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. AmeriHealth Caritas Iowa's goal is to have all providers enrolled with CAQH.

There is no charge to providers to submit applications and participate in CAQH. Providers may access the application forms via AmeriHealth Caritas Iowa's website at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com) and submit to AmeriHealth Caritas Iowa as follows:

- Submit application to participate with AmeriHealth Caritas Iowa via CAQH (PDF).
- Fax or email your CAQH ID number to the AmeriHealth Caritas Iowa Credentialing department at **1-215-863-6369** or [credentialingIA@amerihealthcaritas.com](mailto:credentialingIA@amerihealthcaritas.com)...
- Register for CAQH, if not already enrolled, on the CAQH website [www.caqh.org](http://www.caqh.org).

Providers who are not affiliated with CAQH or prefer a paper credentialing process may obtain credentialing information on [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com) or contact their Provider Network Account Executive for assistance.

## Practitioner Credentialing Rights

During the review of the credentialing application, applicants are entitled to certain rights as listed below. Every applicant has the right to:

- To review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer-review protected information.
- To be notified if any credentialing information is received that varies substantially from application information submitted by the practitioner. As examples, practitioners will be notified of the following types of variances: actions on license, malpractice claim history, suspension or termination of hospital privileges, or board certification decisions; however, variances in information obtained from references, recommendations or other peer-review protected information are not subject to this notification. Practitioners have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his/her application.
- To request the status of his/her application – if the application is current and complete, the applicant can be informed of the tentative date that his or /her application will be presented to the Credentialing Committee for approval.

Questions regarding the status of a credentialing application may be directed to the Credentialing department at **1-855-209-5522**.

AmeriHealth Caritas Iowa's Quality Assessment and Performance Improvement Program (QAPI) provides oversight of the Credentialing department. For more information on the QAPI, please refer to the "Quality Assurance and Performance Improvement Program" section of this *Provider Manual*.

## Credentialing/Re-Credentialing for Practitioners

1. Current, active, unrestrictive medical licensure;
2. No revocation or suspension of the provider's state license by the Iowa Board of Medicine;
3. Current, active, unrestrictive DEA license (DEA licenses are not transferrable by State and must have an Iowa address on them)
4. Current CDS/CSC license
5. Evidence of professional liability insurance with limits of liability commensurate with State requirements;
6. Individual Medicaid Number
7. Individual NPI Number
8. Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the provider and documented in the following sources:
  - a. The National Provider Data Bank – Health Integrity and Provider Data Bank (NPDB)
  - b. Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) – Medicaid and Medicare Exclusions
  - c. Federation of Chiropractic Licensing Boards (CIN-BAD)
  - d. Excluded Parties List System (EPLS)
  - e. System for Award Management (SAM)
  - f. Any other relevant State sanction and licensure databases as applicable.
9. Disclosure related to ownership and management, business transactions and conviction of crimes, in accordance with federal and Iowa regulatory requirements;
10. Proof of the provider's medical school graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency and other postgraduate training;
11. ECFMG Certificate for foreign medical school graduates;
12. Evidence of specialty board certification, if applicable; and,
13. Evidence of the provider's past five years of professional liability claims history.
14. Work history with no gaps greater than 6 months;
15. CLIA Certificate, if applicable

In addition, AmeriHealth Caritas Iowa's credentialing and re-credentialing processes include verification of the following additional requirements for physicians and must ensure compliance with federal and Iowa requirements:

1. Privileges in good standing at a participating hospital designated by the practitioner as the primary admitting facility; or, if the practitioner does not have admitting privileges, privileges in good standing at the hospital for another provider with whom the practitioner has entered into an arrangement for hospital coverage.

## Credentialing/Re-Credentialing for Ancillary/Hospital Providers

AmeriHealth Caritas Iowa verifies credentialing and re-credentialing criteria for all ancillary and hospital providers. AmeriHealth Caritas Iowa's criteria include:

1. Current, active, unrestrictive facility licensure;
2. No revocation or suspension of the provider's state license by the Iowa Board of Medicine;
3. Current accreditation with an AmeriHealth Caritas Iowa recognized accrediting body;
4. If not accredited, a CMS State Survey is required. If the provider does not have either accreditation or a CMS State Survey, a Plan Site Visit must be conducted;
5. Evidence of professional liability insurance with limits of liability commensurate with State requirements;
6. Group Medicaid Number
7. Group NPI Number
8. Satisfactory review of any quality issues, sanctions and/or exclusions imposed on the provider and documented in the following sources:
  - a. The National Provider Data Bank – Health Integrity and Provider Data Bank (NPDB)
  - b. Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) – Medicaid and Medicare Exclusions
  - c. Excluded Parties List System (EPLS)
  - d. System for Award Management (SAM)
  - e. Any other relevant State sanction and licensure databases as applicable.
9. Disclosure related to ownership and management, business transactions and conviction of crimes, in accordance with federal and Iowa regulatory requirements;

All applications and attestation/release forms must be signed and dated within 120 days prior to the Credentialing Committee or Medical Director approval date. Additionally, all supporting documents must be current at the time of the decision date.

### Initial Site Visit Review

AmeriHealth Caritas Iowa's credentialing process includes provisions that new practitioners (and new practice locations) are required to meet minimal criteria for office settings and medical record keeping in order to be considered for inclusion in the provider network. These initial site visit requirements apply to practitioners joining previously surveyed locations, as well as the new practice locations of previously surveyed practitioners. The following practitioner types require a site visit: PCP's, OB/GYN's, high and volume behavioral health providers

Site Visits will also be conducted for those ancillary/hospital providers who are not accredited or who do not have a CMS State Survey completed.

To address any areas of deficiency identified on the initial visit, AmeriHealth Caritas Iowa requires a corrective action plan be submitted to the Plan within one week of the visit. Re-survey of the site will occur within 30 days to ensure compliance has been met. Practitioners not meeting the minimal performance standard threshold of 85% will be reviewed by the AmeriHealth Caritas Iowa Medical Director and Credentialing Committee for recommendation.

In addition to the initial site visit, all practice/site locations will receive a re-evaluation visit every three years.

### Site Visits Resulting from Receipt of a Complaint and/or On-going Monitoring

#### Member Dissatisfaction Regarding Office Environment

- The Provider Services department or the Credentialing department may identify the need for a site visit due to receipt of a member dissatisfaction regarding the provider's office environment.

- At the discretion of the Provider Network Account Executive, a site visit may occur to address the specific issue(s) raised by a member. Follow-up site visits are conducted as necessary.
- Focused site visits, where the full Site Visit Evaluation is not performed, do not count toward the three-year site visit requirements.

### Communication of Results

- The Provider Network Account Executive reviews the results of the Site Visit Evaluation Form (indicating all deficiencies) with the office contact person.
- If the site meets and/or exceeds the passing score:
- The Site Visit Evaluation Form is signed and dated by both AmeriHealth Caritas Iowa and the office contact person.
- If the site does not receive a passing score, AmeriHealth Caritas Iowa follows the procedures outlined below in the follow-up procedure for initial deficiencies.

### Follow-Up Procedure for Initial Deficiencies

- The Provider Network Account Executive requests a corrective action plan from the office contact person. The corrective action plan must be submitted to AmeriHealth Caritas Iowa within one week of the visit.
- Each follow-up contact and visit is documented in the provider's electronic file.
- The Provider Network Account Executive schedules a re-evaluation visit with the provider office within 30 days of the initial site visit to review the site and verify that the deficiencies were corrected.
- The Provider Network Account Executive reviews the corrective action plan with the office contact person.
- The Provider Network Account Executive reviews the results of the follow-up Site Visit Evaluation Form (including a re-review of previous deficiencies) with the office contact person
- If the site meets and/or exceeds the passing score, the Site Visit Evaluation Form is signed and dated by both the Provider Network Account Executive and the office contact person.
  - If the site does not meet and/or exceed the passing score the Provider Network Account Executive follows the procedures outlined below for follow-up for secondary deficiencies.

### Follow-Up Procedure for Secondary Deficiencies

The Provider Network Account Executive will re-evaluate the site monthly, up to three times (from the first site visit date).

If after four months, there is evidence the deficiency is not being corrected or completed, then the office receives a failing score unless there are extenuating circumstances.

Further decisions as to whether to pursue the credentialing process or take action to terminate participation of a provider who continues to receive a failing Site Visit Evaluation score will be handled on a case-by-case basis by the AmeriHealth Caritas Iowa Medical Director and Credentialing Committee.

### Re-Credentialing of Practitioners

AmeriHealth Caritas Iowa will re-credential network practitioners at least every three years. The following information is requested in order to complete the re-credentialing process:

1. Application –CAQH Universal Provider Data Source or Paper Application
2. Practitioner CAQH Reference Number
3. Credentialing Attestation and Release Form as part of the CAQH or paper application
4. Office Hours / Service Addresses
5. Supporting Documents – State Professional License, Federal DEA Registration, State-Controlled Substance Certificate, Malpractice Face Sheet and Clinical Laboratory Improvement Amendments (CLIA) Certificate (if applicable)
6. Individual Medicaid Number
7. Individual NPI Number



## Re-Credentialing of Ancillary/Hospital Providers

AmeriHealth Caritas Iowa will recertify network providers at least every three years. The following information is requested in order to complete the recertification process:

1. Supporting Documents – State Professional License,
2. Malpractice Face Sheet
3. Current accreditation with an AmeriHealth Caritas Iowa recognized accrediting body;
4. If not accredited, a CMS State Survey is required. If the provider does not have either accreditation or a CMS State Survey, a Plan Site Visit must be conducted;
5. Group Medicaid Number
6. Group NPI Number

As with initial credentialing, all applications and attestation/release forms must be signed and dated 120 days prior to the Credentialing Committee or Medical Director approval date. Additionally, all supporting documents must be current at the time of the decision date.

## STANDARDS FOR PARTICIPATION

By agreeing to provide services to AmeriHealth Caritas Iowa members, providers must:

- Be eligible to participate in any Iowa or federal health care benefit program.
- Comply with all pertinent Medicaid regulations.
- Treat AmeriHealth Caritas Iowa members in the same manner as other patients.
- Provide covered services to all AmeriHealth Caritas Iowa members who select or are referred to you as a provider.
- Provide covered services without regard to religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status. All providers must comply with the requirements of the Americans with Disabilities Act (ADA) and Section 504 of Rehabilitation Act of 1974.
- Not segregate members from other patients (applies to services, supplies and equipment).
- Not refuse to provide services to members due to a delay in eligibility updates.

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, AmeriHealth Caritas Iowa may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other federal health care programs.

A sanctioned person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Upon request of AmeriHealth Caritas Iowa, a provider will be required to furnish a written certification to the Plan that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a sanctioned person.

A provider is required to immediately notify AmeriHealth Caritas Iowa upon knowledge that any of its AmeriHealth Caritas Iowa, employees, directors, officers or owners has become a sanctioned person, or is under any type of investigation which may result in their becoming a sanctioned person. In the event that a provider cannot provide reasonably satisfactory assurance to AmeriHealth Caritas Iowa that a sanctioned person will not receive payment from the Plan under the Provider Agreement, AmeriHealth Caritas Iowa may immediately terminate the Provider Agreement. The

Plan reserves the right to recover all amounts paid by AmeriHealth Caritas Iowa for items or services furnished by a sanctioned person.

## Access to Care

AmeriHealth Caritas Iowa providers must meet standard guidelines as outlined in this publication to help ensure that Plan members have timely access to care.

AmeriHealth Caritas Iowa endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. The Plan establishes mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for members should comply with the access standards defined below. The standards below apply to health care services and medical providers; please refer to the “Behavioral Health Care” section of this *Provider Manual* for the standards that apply to behavioral health care services and behavioral health providers.

AmeriHealth Caritas Iowa monitors the following access standards on an annual basis per Iowa guidelines. If a provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Network Account Executive or the Provider Services department at **1-844-411-0579**.

Access to Health care	
Hospitals	Not to exceed thirty (30) minutes except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards
Emergency Health care (Life Threatening)	All emergency care is immediate at the nearest facility available, regardless of whether the facility or provider participate in the AmeriHealth Caritas Iowa network.
Urgent Health care	Within one (1) day of presentation at a service delivery site or within twenty-four (24) hours of telephone contact.
Mobile Crisis ( <i>Behavioral Health</i> )	Members in need of mobile crisis services shall receive service within one (1) hour of presentation or request.
Persistent symptoms	Within forty-eight (48) hours of request
PCP Distance/Time	Thirty (30) miles or thirty (30) minutes from the personal residences of all members
PCP Routine Appointment	Not to exceed four (4) to six (6) weeks from the date of a patients request for a routine appointment
Specialty Care	Sixty (60) miles from the personal residence of members for at least 75% of non-dual members In the event that the specialty care provider required is not represented in the participating provider network, the PCP shall refer the member to non-network providers.
Initial Appointments for New Members Under Age 21	Within 30 Days



Initial Appointments for New Members Ages 21 and Older	Within 30 Days of Request OR Within 45 Days of Becoming a Member, whichever is sooner
Initial Appointments for Pregnant Women or Family Planning Services	Within 10 Days of Request
Substance Abuse & Pregnancy	Pregnant members in need of routine substance abuse services must be admitted within forty-eight (48) hours of seeking treatment.
Intravenous drug use	Members who are intravenous drug users must be admitted not later than fourteen (14) days after making the request for admission, or one-hundred and twenty (120) days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than forty-eight (48) hours after such request.
Waiting Time in a Provider Office	Not to exceed 45 minutes for Members arriving at the scheduled appointment time
Optometry Services	Not to exceed (30) minutes except in rural areas where community standards and documentation shall apply. Not to exceed 3 weeks for regular appointments and forty-eight (48) hours for urgent care.
Lab and X-Ray Services	Not to exceed (30) minutes except in rural areas where community standards and documentation shall apply. Not to exceed 3 weeks for regular appointments and forty-eight (48) hours for urgent care. Labs must have Clinical Laboratory Improvement Amendments (CLIA) certificates in accordance with CLIA law.
Pharmacies	Thirty 30 miles or thirty (30) minutes from a member's residence
Use of Free Interpreter Services	As Needed Upon Member Request During All Appointments

## Missed Appointment Tracking

If a member misses an appointment with a provider, the provider should document the missed appointment in the member's medical record. Providers should make at least three documented attempts to contact the member and determine the reason. The medical record should reflect any reasons for delays in providing health care, as a result of missed appointments, and should also include any refusals by the member. Providers are encouraged to advise AmeriHealth Caritas Iowa's Rapid Response team at **1-855-332-2440, prompt #3** if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.

## After-Hours Accessibility

AmeriHealth Caritas Iowa members have access to quality, comprehensive health care services **24 hours a day, seven days a week**. PCPs must have either an answering machine or an answering service for members during after-hours for non-emergent issues. The answering service must forward calls to the PCP or on-call provider, or instruct the member that the provider will contact the member within 30 minutes. When an answering machine is used after hours, the answering machine must provide the member with a process for reaching a provider after hours. The after-hours coverage must be accessible using the medical office's daytime telephone number.

For emergent issues, both the answering service and answering machine must direct the member to call 911 or go to the nearest emergency room. AmeriHealth Caritas Iowa will monitor access to after-hours care on an annual basis by conducting a survey of PCP offices after normal business hours.

## Monitoring Appointment Access and After-Hours Access

AmeriHealth Caritas Iowa will monitor appointment waiting times and after-hours access using various mechanisms, including:

- Reviewing provider records during site reviews;
- Monitoring administrative complaints and grievances; and,
- Conducting an annual *Access to Care* survey to assess member access to daytime appointments and after-hours care.

Non-compliant providers will be subject to corrective action and/or termination from the network, as follows:

- A non-compliance letter will be sent to the provider.
- The non-compliant provider will be re-surveyed within three to six months after the infraction.

## Panel Capacity & Notification

When members choose a provider as their PCP, they are assigned to the provider's panel of members. The panel remains open unless the following occurs:

- The PCP is under sanction;
- The PCP has voluntarily closed his/her panel; or,
- The panel is closed by AmeriHealth Caritas Iowa due to member access issues.

AmeriHealth Caritas Iowa PCPs must have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards including CMS and/or the Iowa DHS guidance on this issue. In evaluating the capacity of PCPs, AmeriHealth Caritas Iowa shall take into consideration both a PCP's existing AmeriHealth Caritas Iowa member load, overall member load (across all programs), Medicaid patient load, as well as its total patient load and will assess the overall patient load against community standards for any specialty involved. AmeriHealth Caritas Iowa will also consider whether the provider is in compliance with the Access Standards set forth in this *Provider Manual*. AmeriHealth Caritas Iowa will not assign additional members to a single PCP if the Plan believes that PCP has reached the capacity to provide high quality services to Plan members.

## PRACTITIONER & PROVIDER RESPONSIBILITIES

### Responsibilities of All Providers

AmeriHealth Caritas Iowa is regulated by Iowa and federal laws. Providers who participate in AmeriHealth Caritas Iowa have responsibilities, including but not limited to:

- Be compliant with all applicable federal and/or state regulations.
- Treat AmeriHealth Caritas Iowa members in the same manner as other patients.
- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., vaccines for children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.
- Comply with all disease notification laws in Iowa.
- Provide information to AmeriHealth Caritas Iowa and/or the Iowa DHS as required.
- Inform members about all treatment options, regardless of cost or whether such services are covered by the Plan or other State programs.
- Maintain a communication network providing necessary information to any Mental Health/Substance Abuse (MH/SA) services provider as frequently as necessary based on the member's needs.

**Note:** Many MH/SA services require concurrent and related medical services, and vice versa. These services include, but are not limited to, anesthesiology, laboratory services, EKGs, EEGs and scans. The responsibility for

coordinating case management activities is shared by providers in both areas. A focused effort to coordinate the provision, authorization, payment and continuity of care is a priority for providers participating in the Iowa Medicaid managed care program. Each medical/surgical plan must monitor overall coordination between these two service areas (i.e., medical/surgical and MH/SA).

- As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment or transfer a member or otherwise discriminate against a member solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status or type of illness or condition, except when that illness or condition may be better treated by another provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the member's special needs.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Provider Agreement (to which this *Provider Manual* and any revisions or updates are incorporated by reference).
- Accept AmeriHealth Caritas Iowa payment or third party resource as payment-in-full for covered services.
- Comply fully with AmeriHealth Caritas Iowa's Quality Improvement, Utilization Management, Integrated Care Management, Credentialing and Audit Programs.
- Comply with all applicable training requirements as required by AmeriHealth Caritas Iowa, Iowa and/or CMS.
- Promptly notify AmeriHealth Caritas Iowa of claims processing payment or encounter data reporting errors.
- Maintain all records required by law regarding services rendered for the applicable period of time, making such records and other information available to AmeriHealth Caritas Iowa or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA Administrative Simplification and HITECH requirements.
- Immediately notify AmeriHealth Caritas Iowa of adverse actions against license or accreditation status.
- Comply with all applicable federal, state, and local laws and regulations.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify AmeriHealth Caritas Iowa of the intent to terminate the Provider Agreement as a participating provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement.
- Verify member eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization for applicable services.
- Maintain hospital privileges when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- Report known or suspected child, elder or domestic abuse to local law authorities and have established procedures for these cases.
- Inform member(s) of the availability of AmeriHealth Caritas Iowa's interpretive services and encourage the use of such services, as needed.
- Notify AmeriHealth Caritas Iowa of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the Provider Agreement.
- Maintain oversight of non-physician practitioners as mandated by Iowa and federal law.
- Agreeing that claims data, medical records, practitioner and provider performance data, and other sources of information, may be used by the Plan to measure and improve the health care delivery services to members.

## Primary Care Provider (PCP) Responsibilities

A Primary Care Provider (PCP) serves as the member's personal practitioner and is responsible for coordinating and managing the medical needs of a panel of AmeriHealth Caritas Iowa members. Practitioners in the following specialties may serve as Plan PCPs:

- General Practice
- Pediatrics
- Internal Medicine
- Osteopath
- Obstetrics/Gynecology
- Family Practice

Additionally, clinics, Federally Qualified Health Centers and nurse practitioners (practicing in the areas listed above) may also serve as PCPs.

A PCP is responsible to AmeriHealth Caritas Iowa and its members for diagnostic services, care planning and Treatment Plan development. The PCP is expected to work with the Plan to monitor treatment planning and provision of treatment.

All new AmeriHealth Caritas Iowa adult and child members with a newly-assigned PCP, who has not previously cared for the member, must receive a comprehensive initial examination and a screening for mental health and substance abuse. The mental health and substance abuse screening must be completed using a validated screening tool, approved by AmeriHealth Caritas Iowa. This screening tool can be found under the "Forms" in the provider section of our website [www.amerihealthcaritasia.com](http://www.amerihealthcaritasia.com).

For the initial examination and assessment of a child, the PCP is required to perform the relevant EPSDT screenings and services, as well as any additional assessment, using the appropriate tools to determine whether or not a child has special health care needs. The PCP must report the determination to the AmeriHealth Caritas Iowa Rapid Response team at **1-855-332-2440, prompt #3**.

For on-going care, the mental health and substance abuse screening must also be administered as a routine part of every child and adult preventive health examination.

AmeriHealth Caritas Iowa PCPs are also expected to assist members with accessing substance abuse, mental health services, and long term services and supports as needed. The Rapid Response team is available to members and providers to support care coordination and access to services. Members and providers may request Rapid Response support by calling **1-855-332-2440, prompt #3**.

In addition, the PCP is responsible for:

- Providing covered services to all assigned members and complying with all requirements for prior authorization.
- Providing assigned members with a medical home including, when medically necessary, coordinating appropriate referrals to services that typically extend beyond those services provided by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services and other community based agency services.
- Providing continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours, seven days per week.
- Managing and coordinating the health care of a member with a participating specialist(s), and/or behavioral health provider;
- Early identification of all members, including children, with special health care needs and notification to the Rapid Response team regarding any such identification as soon as possible;
- Collaboration with AmeriHealth Caritas Iowa's Integrated Care Management programs to facilitate member care;

- Use of a valid and standardized developmental screening tool, approved by the Plan, to screen for developmental delays during well-child visits, episodic visits or as a stand-alone service;
- Referral of a child, identified as having a developmental delay, to the appropriate specialist for a comprehensive developmental evaluation;
- Documentation of all diagnoses and care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas Iowa's Medical Record Documentation Requirements, as described under "Compliance Requirements" in this section of the *Provider Manual*;
- Providing follow-up services for members who have been seen in the Emergency Department;
- Promptly and accurately reporting all member encounters to AmeriHealth Caritas Iowa;
- Releasing medical record information upon written consent or request of the member;
- Providing preventive healthcare to members according to established preventive health care guidelines;
- Advising the Rapid Response team at **1-855-332-2440, prompt #3** if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.
- Advising AmeriHealth Caritas Iowa ninety (90) days in advance of the effective date if they elect to decline accepting additional members.
- Advising AmeriHealth Caritas Iowa at least 60 days in advance of any addition or change in office location.

### OB/GYN Practitioner as a PCP

Participating Obstetricians are responsible for medical services during the course of the member's pregnancy, and for coordinating testing and referral services. Obstetricians may also provide routine primary care and treatment to pregnant members under their care. Examples of routine primary care include but are not limited to:

- Treatment of minor colds, sore throat, asthma
- Treatment of minor physical injuries
- Preventive health screenings and maintenance
- Routine gynecological care

The OB/GYN is also responsible for notifying the Bright Start® Care Managers at **1-855-332-2440** for assistance with support services needed to help a member during pregnancy.

Prenatal care providers are expected to complete the Iowa Integrated Screen to assess risk for each expectant mother. The completed screening tool must be submitted to AmeriHealth Caritas Iowa as part of the authorization for obstetric services.

It is the provider's responsibility to address identified risk factors upon contact with the member and to develop appropriate action items in collaboration with the member to resolve the identified risks. Pregnancies that are considered high-risk due to physical, social or behavioral conditions must also be reported to the Plan at the time of the first visit or at the time when the high-risk situation is identified during the pregnancy. All high-risk conditions should be reported to a Bright Start® Care Manager at **1-855-332-2440**. Providers can fax reports to Bright Start® through the member's services fax number: **1-844-214-2465**.

### Specialist Responsibilities

An AmeriHealth Caritas Iowa specialist is responsible for:

- Providing specialty care as indicated by the referring practitioner;
- Reporting clinical findings to the referring PCP;
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the member, as requested by the referring practitioner;
- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas Iowa's Medical Record Documentation Requirements, as described in the "Quality Assurance and Performance Improvement Program" section of this *Provider Manual*;
- Refraining from referring members to other specialists without the intervention of the member's PCP;



- Verifying a member's eligibility prior to the provision of services.

## COMPLIANCE RESPONSIBILITIES

AmeriHealth Caritas Iowa providers are required to comply with all Plan policies and with all relevant legal or regulatory standards, as set by outside legal or regulatory authorities. Although not an exclusive list, the primary areas of compliance with policies and regulations for Plan providers are:

- Americans with Disabilities Act (ADA) / Rehabilitation Act
- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud, Waste & Abuse (FWA)
- False Claims Act
- Advance Directives
- Marketing Activities Guidelines

### The Americans with Disabilities Act (ADA) and the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 ("Rehab Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require the Plan's providers to make their services and facilities accessible to all individuals. AmeriHealth Caritas Iowa expects its network providers to be familiar with the requirements of the Rehabilitation Act and the ADA and to fully comply with the requirements of these statutes.

### Health Insurance Portability and Accountability Act (HIPAA)

AmeriHealth Caritas Iowa is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects its practitioners and providers to be familiar with their HIPAA responsibilities and to take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other data on a member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

### Fraud, Waste and Abuse (FWA)

AmeriHealth Caritas Iowa has a designated Medicaid Compliance Officer who carries out the provisions of AmeriHealth Caritas Iowa's compliance plan, which includes the Plan's fraud, waste and abuse (FWA) programs. Designed in accordance with federal and Iowa rules and regulations, the Plan's compliance program is aimed at preventing and detecting activities that constitute FWA. The program includes FWA policies and procedures, investigation of unusual incidents and implementation of corrective action. AmeriHealth Caritas Iowa has provider reference materials that are available by contacting the Provider Services department. The materials include information regarding:

#### Fraud

"Fraud" is an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law. As applied to the federal health care programs (including the Medicaid program), health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a federal health care program. Some examples of fraud include:

- Billing for services not furnished;
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients;
- Soliciting, offering or receiving a kickback, bribe or rebate; and/or,
- Violations of the physician self-referral prohibition.

## Waste

Though not defined by the Medicaid Fraud and Patient Abuse Unit of the Attorney General, “waste” means to use or expend carelessly, extravagantly, or to no purpose.

## Abuse

“Abuse” is defined as provider practices that are inconsistent with generally accepted business or medical practice and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid program. In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicaid program. Some examples of abuse include:

- Charging in excess for services or supplies;
- Providing, referring, or prescribing medically unnecessary services or items;
- Providing services that do not meet professionally recognized standards.

## False Claims Act

The Federal False Claims Act (FCA) is a federal law that applies to fraud involving any contract or program that is federally funded, including Medicare and Medicaid. It prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contractors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. Health care entities that violate the Federal FCA can be subject to imprisonment and civil monetary penalties ranging from \$5,000 to \$11,000 for each false claim submitted to the United States government or its contractors, including state Medicaid agencies, as well as possible exclusion from Federal Government health care programs.

The Federal FCA contains a “qui tam” or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The FCA protects individuals who report under the qui tam provisions from retaliation that results from filing an action under the Act, investigating a false claim, or providing testimony for or assistance in a Federal FCA action.

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the False Claims Act (FCA). Penalties for violations of FERA are comparable to penalties for violation of the FCA. FERA does the following:

- Expands potential liability under the FCA for government like AmeriHealth Caritas Iowa.
- Expands the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government AmeriHealth Caritas Iowa like AmeriHealth Caritas Iowa.
- Expands the definition of false record to include any record that is material to a false/fraudulent claim.
- Expands whistleblower protections to include AmeriHealth Caritas Iowa and agents who claim they were retaliated against for reporting potential fraud violations.

## Reporting and Preventing FWA

AmeriHealth Caritas Iowa receives state and federal funding for payment of services provided to our members. In accepting claims payment from AmeriHealth Caritas Iowa, providers are receiving Iowa and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse against the medical assistance program. Compliance with federal laws and regulations is a priority of AmeriHealth Caritas Iowa.

If you, or any entity with which you contract to provide health care services on behalf of AmeriHealth Caritas Iowa beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact AmeriHealth Caritas Iowa by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**.
- Emailing to [fraudtip@amerihealthcaritas.com](mailto:fraudtip@amerihealthcaritas.com); or
- Mailing a written statement to Special Investigations Unit, AmeriHealth Caritas Iowa, 200 Stevens Drive, Philadelphia, PA, 19113.

Below are examples of information that will assist the Plan with an investigation:

- Contact Information (e.g. name of individual making the allegation, address, telephone number)
- Name and Identification Number of the Suspected Individual
- Source of the Complaint (including the type of item or service involved in the allegation)
- Approximate Dollars Involved (if known)
- Place of Service
- Description of the Alleged Fraudulent or Abuse Activities
- Timeframe of the Allegation(s)

The Plan will report possible fraud or abuse activity to the Iowa's Medicaid Fraud Control Unit (MFCU) and appropriate law enforcement. The Plan cooperates fully in fraud and abuse investigations conducted by state and/or federal agencies, including but not limited to the Federal Bureau of Investigation, the Drug Enforcement Administration, the Office of Inspector General, US Department of Health and Human Services.

The Iowa DHS investigates activities relating to the prevention, detection and investigation of alleged provider and recipient fraud and/or abuse in Medicaid and other programs. You may report suspected fraud by calling **1-800-831-1394**, available Monday – Friday 7:00 am to 6:00 pm. You may also report suspected fraud to the US Department of Health and Human Services at the Office of the Inspector General by calling **1-800-447-8477** or mailing your submission to: US Department of Health and Human Services, Office of the Inspector General, ATTN: OIG HOTLINE OPERATIONS, P.O. Box 23489, Washington, DC 20026.

## PROGRAM INTEGRITY

The Program Integrity Department is responsible for identifying and offsetting claim overpayments for the Medicaid population which AmeriHealth Caritas Iowa serves. The department performs several operational activities to ensure the accuracy of claim payments.

The Program Integrity Department utilizes internal resources and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from AmeriHealth Caritas Iowa, or on behalf of AmeriHealth Caritas Iowa, regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided on the letter to expedite a response to your question or concerns.

## ADVANCED DIRECTIVES

All participating Plan providers are required to facilitate advance directives for individuals as defined in 42 C.F.R 489.100. The Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to providing health care when an individual is incapacitated. If a member is an adult (18 years of age or older), he/she has the right under federal law to decide what health care that he/she wants to receive, if in the future the member is unable to make his/her wishes known about medical treatment. The member has the right to choose a person to act on his or her behalf to make health care decisions for them, if the members cannot make the decision for themselves.

AmeriHealth Caritas Iowa requires its contracted providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advanced directives must be furnished by providers and/or organizations as required by federal regulations:



- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.
- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Personal Care Services - In advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

Additionally, providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.
- Implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive; state law allows any health care provider or any agent of such provider to conscientiously object.

Please see Appendix A at the end of this manual for the Iowa State Advance Directive, *Gift of Peace of Mind, for yourself, for your Family*", published by the Drake Center for Health Issues, May, 2011.

## Provider Marketing Activities Guidelines

As a contracted provider, you are permitted to share the following with Plan members:

- General and factual information about AmeriHealth Caritas Iowa and your participation in the Plan's network.
- Plan-provided member education materials that have been approved by the Plan and the Iowa DHS.
- Contact information for the Medicaid enrollment broker.

As a contracted provider, you are **prohibited from participating in the following activities**:

- Using written or oral methods of communication with members to compare benefits or other aspects of Medicaid managed care organizations.
- Using written or oral methods of communication to share false or misleading information regarding the Plan or the provision of services.
- Performing direct marketing activities or other marketing activities on behalf of the Plan.
- Performing or permitting any marketing activities on behalf of the Plan at your office location.
- Using marketing materials that have not been approved by the Plan and the Iowa DHS.
- Assisting with or making recommendations for enrollment with the Plan, except to refer prospective members to the Medicaid enrollment broker.

## PROVIDER SUPPORT & ACCOUNTABILITY

### Provider Network Management

AmeriHealth Caritas Iowa's Provider Network Account Executives function as a provider relations team to advise and educate AmeriHealth Caritas Iowa providers. Provider Network Account Executives assist providers in adopting new business policies, processes and initiatives. From time to time, providers will be contacted by Plan representatives to conduct meetings that address topics including, but not limited to:

- Contract Terms
- Credentialing or Re-credentialing Site Visits
- Health Management Programs
- Orientation, Education and Training
- Program Updates and Changes
- Provider Complaints

- Provider Responsibilities
- Quality Enhancements
- Self-Service Tools

## New Provider Orientation

Upon completion of AmeriHealth Caritas Iowa's contracting and credentialing processes, the provider receives a welcome letter, which includes the effective date and the Account Executive's contact information. The welcome letter refers all Plan providers to online resources, including AmeriHealth Caritas Iowa provider orientation and training information and this *Provider Manual*. The *Provider Manual* serves as a source of information regarding the Plan's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to support provider compliance with all provider contract requirements. The welcome letter explains how to request a hard copy of this *Provider Manual* by contacting the Provider Services department at **1-844-411-0579**.

## Orientation Training

AmeriHealth Caritas Iowa will conduct initial training within 30 days of placing a newly contracted provider, or provider group, on active status. Orientation training topics will include:

- Medicaid Program Overview
- Member Access Standards
- Credentialing Processes
- Provider Responsibilities (including Advance Directives, Fraud, Waste & Abuse, Reporting Requirements, IDEA, HIPAA and Privacy, etc.)
- Cultural Competency
- Policies and Procedures
- Utilization Management, Quality Improvement and Integrated Care Management Programs
- Medical Necessity Criteria, Clinical Practice Guidelines and Screening Tools
- Medicaid Compliance
- Covered Services, Benefit Limitations and Value-Added Services
- Co-pays
- Provider Inquiry and Complaint Processes
- Billing, Claims Filing, and Encounter Data Reporting
- Electronic Funds Transfer and Electronic Remittance Advice
- Quality Enhancement Programs/Community Resources
- "Care for Kids" (including an overview of immunizations, nutrition and Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.)

## Mandatory Provider Trainings & Meetings

AmeriHealth Caritas Iowa will provide training on the following topics as required by the IME:

- Critical Incidents
- Abuse, Neglect and Exploitation of Members
  - Preventing
  - Identifying
  - Reporting
  - Investigating
  - Remediating
- Role of Care Coordinator
- LTSS provider training

## Provider Education and On-Going Training

AmeriHealth Caritas Iowa's training and development are fundamental components of continuous quality and superior service. The Plan offers on-going educational opportunities for providers and their staff. Provider training and educational programs are based on routine assessments of provider training and educational needs. The Plan has a commitment to provide all appropriate training and education to ensure providers are compliant with Plan standards, and federal and state regulations. This training may occur in the form of an on-site visit or in an electronic format, such as online or interactive training sessions. Detailed training information is available in the provider area of the AmeriHealth Caritas Iowa website at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com). Plan providers also have access to the Provider Services department at **1-844-411-0579** and their Account Executive for questions.

## Plan-to-Provider Communications

Providers will receive or have access to regular communications from AmeriHealth Caritas Iowa including, but not limited to the following:

- Provider Manual
- Provider Newsletters
- Website Updates and Information
- Provider Notices and Announcements
- Surveys
- Faxes
- Emails
- Miscellaneous Other Materials

## Provider Complaint System

AmeriHealth Caritas Iowa providers may file an informal dispute about the Plan's policies, procedures, or any aspects of the Plan's administrative functions. AmeriHealth Caritas Iowa will thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions. All pertinent facts will be investigated and considered. AmeriHealth Caritas Iowa's policies and procedures will also be considered.

Providers may call Provider Services at **1-844-411-0579** to notify AmeriHealth Caritas Iowa of a complaint. A written notice of the outcome will be sent to the provider within 90 days of receipt of the complaint.

## Provider Contract Terminations

AmeriHealth Caritas Iowa Provider Agreements specify termination provisions that comply with the Iowa DHS requirements. Provider terminations are categorized as follows:

- Provider Initiated
- Plan Initiated "For Cause"
- Plan Initiated "Without Cause"
- Mutual

In addition to those requirements identified in the Provider Agreement, AmeriHealth Caritas Iowa will comply with the following guidelines, based on category of termination.

### Provider Initiated

- The provider must provide written notice to the Plan if intending to terminate from the Plan network. Written notice must be provided at least 90 days before the termination date if without cause and 60 days before termination date with cause. Under either circumstance, written notice must be delivered in accordance with the

method(s) specified in your Provider Agreement and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.

- If the provider is a PCP, the Plan will send a written notification to the members who have chosen the provider as their PCP no less than 15 calendar days after receipt of the termination notice or at least 30 days prior to the termination date, whichever is sooner.
- If a Plan member has special health care needs and his or her treating provider gives notice of termination with the Plan, Member Services and/or Case Management staff will personally contact the member by telephone and in writing to provide assistance in securing a new provider.

### Plan Initiated “For Cause”

AmeriHealth Caritas Iowa may initiate termination of a Provider Agreement if the provider breaches the Plan Provider Agreement. A “for cause” termination may be implemented when there is a need to terminate a provider’s contract. If terminating a Provider Agreement for cause, the Plan will:

- Send applicable termination letters in accordance with the notification provisions of the Provider Agreement.
- Notify the provider, the Iowa DHS and the member immediately in cases where a AmeriHealth Caritas Iowa member’s health is subject to imminent danger or a physician’s ability to practice medicine is effectively impaired by an action of the Iowa Board of Medicine or other governmental agency.
- Provide the Iowa DHS with reason(s) for termination for cause.
- Offer appeal rights for physicians, as applicable.

### Plan Initiated “Without Cause”

AmeriHealth Caritas Iowa may terminate a Provider Agreement “without cause” for various reasons (e.g., provider relocation or dissolution of a medical practice). If this occurs, the Plan will:

- Send applicable termination letters in accordance with the notification provisions of the Provider Agreement.
- Notify the Plan network provider, the Iowa DHS and members in active care at least 30 calendar days before the effective date of the termination.
- Fax all AmeriHealth Caritas Iowa termination letters to the Iowa DHS.
- Offer appeal rights to physicians, as applicable.

### Mutual Terminations

A mutual termination is a termination of a Provider Agreement(s) in which the effective date is agreed upon by both parties. The termination date may be other than the required days’ notice specific to the Plan’s Provider Agreement language.

- All mutual termination letters require signatures by both parties.
- Regarding mutual terminations of any AmeriHealth Caritas Iowa Provider Agreement, the termination date should provide a minimum number of required days in order to provide notice to members. A mutual agreement termination date should not be a retroactive date.
- AmeriHealth Caritas Iowa will notify the Iowa DHS and members in active care at least 30 calendar days before the effective date of the termination.

### Continuity of Care

Plan members who are in active treatment at the time a Provider Agreement terminates will be allowed to continue care with a terminated treating provider, pursuant to the terms of the Provider Agreement, but no less than through the earlier of:

- Completion of treatment for a condition for which the member was receiving care at the time of the termination; or,

- Until the member changes to a new provider.

AmeriHealth Caritas Iowa will allow pregnant members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider through the completion of postpartum care.

Notwithstanding the provisions in this section, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant.

For continued care, AmeriHealth Caritas Iowa and the terminated provider will continue to abide by the same terms and conditions as outlined in the Provider Agreement and in the “Quality Assurance and Performance Improvement Program” section of this *Provider Manual*. These provisions for continuity of care set forth above will not apply to providers who have been terminated from AmeriHealth Caritas Iowa for cause.



## **SECTION III PROVISION OF SERVICES**

## III. Provision of Services

This section provides a summary of the covered services offered to Iowa Health Link enrollees.

No content found in this publication or in the Plan's participating Provider Agreement

ent is intended to prohibit or otherwise restrict a provider from acting within the lawful scope of his or her practice, or to encourage providers to restrict medically-necessary covered services or to limit clinical dialogue with patients. Providers are not prohibited from advising or advocating on behalf of a member who is his or her patient and may discuss the member's health status, health care, treatment options (including any alternative treatment that may be self-administered), information the member needs to make a decision between relevant treatment options, the risks, benefits and consequences of treatment or non-treatment and the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. Regardless of benefit coverage limitations, providers are encouraged to openly discuss all available treatment options with Plan members.

### Iowa Medicaid Covered Benefits and Limitations

For additional information regarding Iowa Medicaid program policies and benefits, go to <https://dhs.iowa.gov/sites/default/files/All-I.pdf>.

SERVICE	LIMITATIONS
1915(C) SERVICES	For each HCBS waiver, there will be an averages pending limit per person for persons enrolled in the waiver. See the 1915(c) Waiver Benefit Grid for covered benefits.
1915(I) HABILITATION SERVICES	For Habilitation, there will be an average aggregate monthly spending limit per person for persons enrolled in the waiver. See the 1915 (i) Waiver Benefit Grid for covered benefits.
Abortions	<p>Abortions may only be authorized in the following situations:</p> <ul style="list-style-type: none"> <li>• If the pregnancy is the result of an act of rape or incest; or</li> <li>• In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.</li> </ul> <p>No other abortions, regardless of funding, can be provided as a benefit under this Contract.</p>
Allergy Testing And Injections	
Anesthesia	
B3 Services	The Plan will use the ASAM criteria as the utilization management guidelines for substance use disorder residential treatment.

SERVICE	LIMITATIONS
Bariatric Surgery	
Bhis (Including Aba)	.
Breast Reconstruction	.
Breast Reduction	
Cardiac Rehabilitation	
Chemotherapy	.
Chiropractic Care (Therapeutic Adjustive Manipulation)	<ul style="list-style-type: none"> <li>• X-ray- payment for documenting x-rays is limited to one per condition. No payment shall be made for subsequent x-rays.</li> <li>• Chiropractic manipulative therapy eligible for reimbursement is specifically limited to the manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by x-ray. There are three categories based off the patient's condition / diagnosis. A diagnosis or combination of diagnoses within category i generally required short-term treatment of 12 per 12-month period. A diagnosis or combination of diagnoses with category ii generally required moderate-term treatment of 18 per 12-month period. A diagnosis or combination of diagnoses within category iii generally required long-term treatment of 24 per 12-month period. For diagnostic combinations between categories, 28 treatments are generally required per 12-month period.</li> </ul>
Colorectal Cancer Screening	
Congenital Abnormalities Correction	
Diabetes Equip And Supplies	.
Diagnostic Genetic Testing	
Dialysis	
Durable Medical Equipment And Supplies	<ul style="list-style-type: none"> <li>• Medical supplies are not to exceed a three-month supply. Diabetic supplies are covered as follows: blood glucose test or reagent strips 6 units per month (1 unit equals 50 strips); urine glucose test strips 3 units per month (1 unit equals 100 strips), lancets 4 units per month (1 unit equals 100 lancets), and needles 500 units per month (1 unit equals 1 needle). Reusable insulin pens are allowed once every six months. Diapers and disposable under pads are covered and can be provided in a 90-day period. Diaper/brief 1,80 per 90-day supply, liner/shield/guard/pad 450 per 90-day supply, pull-on 450 per 90-day supply, disposable under pads 600 per 90-day supply, reusable under pads 48- per 12 months. Maximum units can vary when combinations of incontinence products are used. Hearing aid batteries are covered up to 30 batteries per aid in a 90-day period. Ostomy supplies and accessories are covered one unit</li> </ul>



SERVICE	LIMITATIONS
	<p>per day of regular wear or three units per month of extended wear are allowed. Services are limited to members in a medical facility. No payment is made to medical suppliers for medical supplies or durable medical equipment for members receiving inpatient or outpatient care in a hospital.</p> <ul style="list-style-type: none"> <li>• No payment is made for medical supplies or durable medical equipment for members for whom the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics.</li> <li>• No payment is made for durable medical equipment or supplies for members</li> <li>• In an intermediate care facility for intellectual disability or a facility receiving</li> <li>• Nursing facility payments, except for the following: <ul style="list-style-type: none"> <li>• Catheter (indwelling foley)</li> <li>• Colostomy and ileostomy appliances</li> <li>• Colostomy and ileostomy care dressings, liquid adhesive, and adhesive</li> <li>• Tape</li> <li>• Diabetic supplies (disposable or retractable needles and syringes,</li> <li>• Test-tape, clinitest tablets, and clinistix)</li> <li>• Disposable catheterization trays or sets (sterile)</li> <li>• Disposable bladder irrigation trays or sets (sterile)</li> <li>• Disposable saline enemas (sodium phosphate type, for example)</li> <li>• Hearing aid batteries</li> <li>• Orthotic and prosthetic services, including augmentative communication</li> <li>• Devices</li> <li>• Orthopedic shoes</li> <li>• Repair of member-owned equipment</li> <li>• Oxygen services: Oxygen services for residents in an ICF/ID are included in the per diem and are not payable separately.</li> <li>• Assistive Technology.</li> </ul> </li> </ul>
Emergency Room Services	
EPSDT	
Family Planning	
Foot Care	
General Inpatient Hospital Care	
Genetic Counseling	.
Gynecological Exams	
Hearing Aids	.

SERVICE	LIMITATIONS
Hearing Exams	<ul style="list-style-type: none"> <li>• Prior authorization is required for replacement of a hearing aid less than 4 years old, except when member is a child under 21 years of age.</li> </ul>
Home Health	<ul style="list-style-type: none"> <li>• Skilled nursing is limited to five visits per week.</li> <li>• Home health aide is limited to visits that do not exceed 28 hours per week</li> <li>• Occupational therapy is limited to physician-authorized visits within guidelines for restorative, maintenance or trial therapy</li> <li>• Physical therapy is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy</li> <li>• Speech pathology is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy</li> </ul>
Hospice	.
ICF/ID	Must meet level of care.
Imaging/Diagnostics (MRI, CT, PET)	.
Immunizations	
Infertility Diagnosis And Treatment	.
Inhalation Therapy	
Inpatient Physician Services	.
Inpatient Surgical Services	
Iv Infusion Services	
Lab Tests	
Maternity And Pregnancy Services	.
Medical Transportation	
Mental Health/Behavioral Health Outpatient Treatment	
Mental/Behavioral Health Inpatient Treatment	
Midwife Services	
Non-Emergency Medical Transportation (NEMT)	
Newborn Child Coverage	
Non-Cosmetic	.

SERVICE	LIMITATIONS
Reconstructive Surgery	
Nursing Facility	Must meet level of care.
Nursing Services	<ul style="list-style-type: none"> <li>Private duty nursing and personal care services are covered as a benefit under EPSDT as provided through a home health agency for up to 16 hours per day.</li> </ul>
Nutritional Counseling	
Occupational Therapy	<ul style="list-style-type: none"> <li>Total Medicaid payment for services provided by an independently practicing occupational therapist shall not exceed the therapy cap as disclosed by the centers of Medicare and Medicaid services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. This new law extends the exceptions process for outpatient therapy caps through March 31, 2015. The statutory Medicare Part B outpatient therapy cap for occupational therapy (OT) is \$1,920.</li> </ul>
Orthotics	<ul style="list-style-type: none"> <li>Payment for orthopedic shoes and inserts and therapeutic shoes for members with diabetes are limited as follows: only two pairs of depth shoes per member are allowed in a 12-month period, three pairs of inserts in addition to the non-customized removable inserts provided with depth shoes are allowed in a 12-month period, only two pairs of custom-molded shoes per member are allowed in a 12-month period, two additional pair of inserts for custom-molded shoes are allow in in a 12-month period.</li> </ul>
Outpatient Surgery	AmeriHealth Caritas Iowa to use utilization management guidelines established and approved by Iowa DHS.
Pathology	AmeriHealth Caritas Iowa to use utilization management guidelines established and approved by Iowa DHS.
Pharmacy	<ul style="list-style-type: none"> <li>Prior authorization is required as specified in the Preferred Drug List <a href="http://www.iowamedicaidpdl.com/">http://www.iowamedicaidpdl.com/</a></li> <li>Reimbursement is only for drugs marketed by manufacturers with a signed rebate agreement.</li> <li>Coverage of drugs in the following categories is excluded: (1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act. (2) Drugs used for anorexia, weight gain, or weight loss. (3) Drugs used for cosmetic purposes or hair growth. (4) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee. (5) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)). (6) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a</li> </ul>

SERVICE	LIMITATIONS
	<p>Medicare Part D plan. (7) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility (8) Drugs used for sexual or erectile dysfunction (9) Drugs for symptomatic relief of cough and colds, except listed nonprescription drugs</p> <ul style="list-style-type: none"> <li>Only certain nonprescription (OTC) drugs and non-drugs are covered as listed in 441 Iowa Administrative Code § 78.2(5) and at <a href="http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/nonprescription-drugs/2011-11-09/otclistbythecategory20111101.pdf">http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/nonprescription-drugs/2011-11-09/otclistbythecategory20111101.pdf</a> And <a href="http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/2014-12-12/Non-Drug%20Product%20List%20Effective%201-1-15.pdf">http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/2014-12-12/Non-Drug%20Product%20List%20Effective%201-1-15.pdf</a>.</li> <li>Quantity: up to 31 day supply at a time except contraceptives at 90 day; otc's at minimum quantity of 100 units per prescription or currently available consumer package. Some drugs are limited to an initial 15 day supply, list at: <a href="http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/15-days-supply-list-effective-01-01-15.pdf">http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/15-days-supply-list-effective-01-01-15.pdf</a></li> <li>Monthly quantity limits by drug list at: <a href="http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/quantity-limits-list-1-1-15.pdf">http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/quantity-limits-list-1-1-15.pdf</a></li> <li>Reimbursement at lower of Iowa AAC (WAC if no AAC), FUL or U&amp;C.</li> </ul>
Physical Therapy	<ul style="list-style-type: none"> <li>Total Medicaid payment for services provided by an independently practicing physical therapist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. The statutory Medicare Part B outpatient therapy cap for physical therapy (PT) is \$1,920.</li> </ul>
PMIC	
Primary Care Illness/Injury Physician Services	
Prostate Cancer Screening	
Prosthetics	
Pulmonary Rehabilitation	
Radiation Therapy	
Screening Pap Tests	.
Screening Mammography	
Second Surgical Option	

SERVICE	LIMITATIONS
Skilled Nursing Services	
Sleep Studies	
Specialty Physician Services	.
Speech Therapy	<ul style="list-style-type: none"> <li>Total Medicaid payment for services provided by an independently practicing speech therapist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid Services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. The statutory Medicare Part B outpatient therapy cap for speech therapy (ST) is \$1,920.</li> </ul>
Substance Use Disorder Inpatient treatment	The plan will use the ASAM Criteria as the utilization management guidelines for substance use disorder services.
Substance Use Disorder Outpatient Treatment	The plan will use the ASAM Criteria as the utilization management guidelines for substance use disorder services.
TMJ Treatment	.
Tobacco Cessation	
Tobacco Cessation For Pregnant Women	
Transplant - Organ And Tissue	
Urgent Care Centers/Facilities Emergency Clinics (Non-Hospital Based)	.
Vision Care Exams	<ul style="list-style-type: none"> <li>Routine eye examinations are covered once in a 12-month period.</li> </ul>
Vision Frames And Lenses	<ul style="list-style-type: none"> <li>Frame services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1 through 3 years of age, one frame every 12 months for children 4-7 years of age and once every 24 months after 8 years of age. Safety frames are allowed for children through 7 years of age.</li> <li>Single vision and multifocal lens services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1-3 years of age, once every 12 months for children 4-7 years of age, once every 24 months after 8 years of age.</li> <li>Gas permeable contact lenses are limited as follow: up to 16 lenses for children up to 1 year of age, up to 8 lenses every 12 months for children 1-3 years of age, up to 6 lenses every 12 months for children 4-7 years of age, two lenses every 24 months for members 8 years of age and over.</li> <li>Replacement of glasses that have been lost or damaged beyond</li> </ul>

SERVICE	LIMITATIONS
	repair are covered for adults age 21 and over is limited to once every 12 months. Replacement for lost or damaged glasses for children less than 21 years of age is not limited.
Walk-In Center Services	
X-Rays	

### Iowa Wellness Plan Covered Benefits and Limitations

For additional information regarding Iowa Wellness Plan policies and benefits go to:

[https://dhs.iowa.gov/ime/members/medicaid-a-to-z/iahealthlink/your\\_benefits](https://dhs.iowa.gov/ime/members/medicaid-a-to-z/iahealthlink/your_benefits)

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
1. Ambulatory Services			
Primary Care Illness/injury Physician Services	✓		
Specialty Physician Visits	✓		
Home Health Services	✓	Not Covered: Private Duty Nursing/Personal Care	Not Covered: Procedure code S9122 or REV codes 570 or 571
Chiropractic Care therapeutic adjustive	✓		
Outpatient surgery	✓		
Second Surgical Opinion	✓		
Allergy Testing & Injections	✓		
Chemotherapy- Outpatient	✓		
IV Infusion Services	✓		
Radiation Therapy Outpatient	✓		
Dialysis	✓		
Anesthesia	✓		
Walk-in Centers	✓		
AIDS/HIV parity	✓		

Access to clinical trials	✓	Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.	
Genetic Counseling	✓	Prior authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of treatment and not just informational.	
2. Emergency Services			
Emergency Room Services	✓		
Non-Emergent Emergency Room visit	✓	\$8.00 co-pay may apply for non-emergent visits to ER. See section below for exemptions.	
Emergency Transportation-Ambulance and Air Ambulance	✓	Reviewed for medical necessity prior to payment.	
Urgent Care Centers/Facilities	✓		
3. Hospitalization			
General Inpatient Hospital Care	✓		
Inpatient Physician Services	✓		
Inpatient Surgical Services	✓		
Non-Cosmetic Reconstructive	✓		
Transplant Organ and Tissue	✓	Covered- certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel. Not Covered- transport of living donor, services/supplies related to mechanical or non- human organs, transplant services and supplies not	
Congenital Abnormalities Correction	✓		
Anesthesia	✓		
Hospice Care - Inpatient	✓		



Hospice Respite - Inpatient	✓	Limited to 15 days per lifetime for inpatient respite care. 15 days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than 5	Revenue code for Hospice Respite: 655
Chemotherapy - Inpatient	✓		
Radiation Therapy - Inpatient	✓		
Breast Reconstruction	✓		
4. Maternity & Newborn Care			
Maternity/Pregnancy Services - Pre & Postnatal Care - Delivery & Inpatient maternity -	✓	Member is required to report pregnancy and eligibility for consideration of benefits under the	
Tobacco Cessation for Pregnant Women	✓		
Midwife Services	✓		
Newborn child coverage	✓		
5. Mental Health Behavioral Health Substance Use Disorder			
Mental Health/Behavioral Health Inpatient Treatment	✓	Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019
Mental Health/Behavioral Health Outpatient Treatment	✓	Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid State Plan.	
Substance Use Disorder Inpatient Treatment	✓	Members with disabling substance use disorder will be considered medically exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019
Substance Use Disorder Outpatient Treatment	✓	Members with disabling substance use disorder will be considered medically exempt and enrolled in the Medicaid State Plan.	
6. Prescription Drugs			

Prescription Drugs	✓		
7. Rehabilitative and Habilitative Services and Devices			
Physical Therapy, Occupational Therapy, Speech Therapy	✓	Each therapy is limited to 60 visits per year. Occupational only for upper extremities. Not covered-OT supplies, IP OT/PT in the absence of separate medical condition requiring hospitalization.	Each therapy is limited to 60 per year: Therapy services must be billed with the GP, GO, or GN modifier. Refer to Medicare's guidance on billing of therapy services.
Inhalation therapy	✓	Limit of 60 visits in a 12 month period.	N/A
Medical and Surgical supplies	✓	Non-covered- elastic stockings or bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription.	
Durable Medical Equipment	✓	Non-covered items include: elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that are available	
Orthotics	✓		
Prosthetics	✓		
Cardiac Rehabilitation	✓		
Pulmonary Rehabilitation	✓		
Skilled Nursing Services	✓	Covered in nursing facilities, skilled nursing facilities and hospital swing beds.	This service is limited to 120 days per year.
8. Laboratory Services			
Lab Tests	✓		
X-Rays	✓		
Imaging/Diagnostics MRI	✓		
Sleep Studies	✓	Treatment for snoring not covered. Claims must be for a diagnosis of sleep apnea.	Services 95800-95811 are covered but not with a diagnosis of 786.09.
Diagnostic Genetic Tests	✓	Requires prior authorization	

Pathology	✓		
9. Preventive Wellness Chronic Disease Management			
Preventive Care	✓	Limited to ACA required preventive	
Nutritional Counseling	✓	Max 40 units allowed for 12 month	Not covered: 97802, 97803, G0270
Nutritional Counseling	✓	Max 20 units allowed for 12 month period	Not covered: 97804 & G0271
Counseling and Education Services	✓	Not covered: Bereavement, family, or marriage counseling. Education	N/A
Family Planning	✓		
Vision Care Exams (Adult)	✓	Codes only allowed once per year: 92002, 92004, 92012, 92014. This does not limit the medical exams for members. Medical exams should be coded properly for accurate claim adjudication.	Not covered: V2020, V2025, V2100-V2115, V2118, V2121, V2199, V2200- V2221, V2299, V2300-V2315, V2318- V2321, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520-V2523, V2530-V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326, 92340, 92341, 92342, 92350, 92351
Immunizations	✓	Not covered- immunizations for travel	Not covered: 90476, 90477, 90581, 90585, 90586, 90665, 90690, 90691, 90692, 90693, 90717
Colorectal Cancer Screening	✓		
Screening Mammography	✓	One per year 77057, 77052, G0202	
Hearing Exam (Adult)	✓	Limit of one hearing exam per year. only allowed once per year: 92551, 92552, 92553, 92555, 92556, 92558, 92559, 92560, V5008	Not covered: V5010, V5040, V5050, V5060, V5090, V5120, V5130, V5160, V5170, V5180, V5210, V5220, V5230, V5266, V5267, V5298, V5299

Diabetes - med necessary equip & supplies Education	✓		
Screening Pap tests	✓		
Gynecological exam	✓	One per year	
Prostate cancer screening	✓	One per year for men age 50-64 years	
Foot Care	✓	Must be related to medical condition, routine services are not	
Tobacco Cessation	✓	Immunizations and medical evaluation for nicotine	
10. Pediatric Services including oral & vision			
EPSDT Ages 19 and 20	✓	Covered for ages 19-20	

### Iowa Health and Wellness Plan Benefits Not Covered

Acupuncture	X	Not covered	
Infertility Diagnosis and Treatment	X	Not covered- infertility treatment resulting from voluntary sterilization, relating to collection/purchase of donor semen or eggs, freezing of the same, surrogate services, infertility diagnosis and treatment, and	
Bariatric Surgery	X	Not covered.	Not covered: 00797, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845,
Residential Services	X		
Non-emergency Transportation	X	Covered only for members determined Medically Exempt.	Covered only for members determined Medically Exempt
Tobacco Cessation	X	Not covered	
TMJ	X	Not covered	Not covered for primary diagnosis of: 524.60, 524.61, 524.62, 524.63,
Breast Reduction	X		CPT codes 19318 or 19316, ICD procedure codes: 85.31, 85.32, 85.6. Code

Hearing Aid	X	Not covered	
Frames and lenses	X	Not covered	

## Iowa Family Planning Covered Benefits and Limitations

Family Planning Benefits	<p>Family planning services and supplies are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting.</p> <ul style="list-style-type: none"> <li>• Approved methods of contraception;</li> <li>• Sexually transmitted infection (STI) or sexually transmitted disease (STD) testing, Pap smears and pelvic exams;</li> <li>• Drugs, supplies, or devices related to women’s health services described above that are prescribed by a health care provider; and</li> <li>• Contraceptive management, patient education, and counseling.</li> </ul> <p>The laboratory tests done during an initial family planning visit for contraception may include a Pap smear, screening tests for STIs or STDs, or pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.</p>
Family Planning Related Benefits	<p>“Family planning-related services and supplies” are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state’s regular federal medical assistance percentage (FMAP) rate. Such services are provided because a “family planning-related” problem was defined or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:</p> <ul style="list-style-type: none"> <li>• Colposcopy and procedures done with or during a colposcopy or repeat Pap smear performed as a follow-up to an abnormal Pap smear that was done as part of a routine periodic family planning visit.</li> <li>• Drugs for the treatment of STIs or STDs, except for HIV/AIDS and hepatitis, when the STI or STD is identified or diagnosed during a routine periodic family planning visit. A follow-up visit or encounter for the treatment or drugs and subsequent follow-up visits to rescreen for STIs or STDs based on the Centers for Disease Control and Prevention guidelines may be covered.</li> <li>• Drugs or treatment for vaginal infections or disorders, other lower genital tract and genital skin infections or disorders, and urinary tract infections, where these conditions are identified or diagnosed during a routine periodic family planning visit. A follow-up visit or encounter for the treatment or drugs may also be covered.</li> <li>• Other medical diagnosis, treatment, and preventative services that are routinely provided pursuant to family planning services in a family planning setting.</li> <li>• Treatment of major complications arising from a family planning procedure, such</li> </ul>

	<p>as:</p> <ul style="list-style-type: none"> <li>• Treatment of a perforated uterus due to an intrauterine device insertion;</li> <li>• Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or</li> <li>• Treatment of surgical or anesthesia-related complications during a sterilization procedure.</li> </ul>
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## **HAWK-I Covered Benefits and Limitations**

For additional information regarding hawk-i policies and benefits go to: [www.hawk-i.org](http://www.hawk-i.org).

<p>Inpatient hospital services</p> <ul style="list-style-type: none"> <li>• Medical</li> <li>• Surgical</li> <li>• Intensive care unit</li> <li>• Mental health</li> <li>• Substance use disorder</li> </ul>
<p>Physician services</p> <ul style="list-style-type: none"> <li>• Surgical</li> <li>• Medical</li> <li>• Office visits</li> <li>• Newborn care</li> <li>• Well-baby</li> <li>• Well-child</li> <li>• Immunizations</li> <li>• Urgent care</li> <li>• Specialist care</li> <li>• Allergy testing and treatment</li> <li>• Mental health visits</li> <li>• Substance use disorder visits</li> </ul> <p>AmeriHealth Caritas Iowa will use the Recommended Childhood Immunization Schedule approved by the Advisory Committee on Immunization Practices (ACIP), The American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), as the immunization schedule. AmeriHealth Caritas Iowa shall incorporate the "Recommendations for Preventive Pediatric Health Care" by the AAP as the schedule for preventive care for children and adolescents.</p> <p>In lieu of the above, AmeriHealth Caritas Iowa may use the most current version of the U.S. Preventive Task Force, "Guide to Clinical Preventive Services" as the immunization and preventive care schedule for children and adolescents.</p>
<p>Outpatient hospital services</p> <ul style="list-style-type: none"> <li>• Emergency room</li> <li>• Non-Emergent Emergency Room Visit: \$25.00 co-pay may apply. See section below for exemptions.</li> <li>• Surgery</li> <li>• Lab</li> <li>• X-ray</li> <li>• Other services</li> </ul>

Ambulance services
Physical therapy
Nursing care services (including skilled nursing facility services)
Speech therapy
Durable medical equipment
Home health care
Hospice services
Prescription drugs
Hearing services
Vision services (including corrective lenses)
Maternity and mental health services not inconsistent with 42 U.S.C.A § 1396u-2(b)(8)

## 1915 (c) and 1915 (i) Waiver Services

**Services, Limitations, member eligibility vary by type of waiver. For the most comprehensive and current information reference the Iowa HCBS provider manual at:**

<https://dhs.iowa.gov/sites/default/files/HCBS.pdf>

Service	Covered Benefit
Aids/HIV	Adult Day Care • Consumer Directed Attendant Care • Counseling Services • Home Delivered Meals • Home Health Aide • Homemaker Services • Nursing Care • Respite • Consumer Choices Option
Brain Injury	• Adult Day Care • Behavioral Programming • Case Management • Consumer Directed Attendant Care • Family Counseling and Training • Home and Vehicle Modifications • Interim Medical Monitoring and Treatment • Personal Emergency Response System • Prevocational Services • Respite • Specialized Medical Equipment • Supported Community Living • Supported Employment • Transportation • Consumer Choices Option
Children's Mental Health	• Environmental Modifications and Adaptive Devices • Family and Community Support Services • In Home Family Therapy • Respite
Elderly	Adult Day Care • Assistive Devices • Assisted Living on-call



Service	Covered Benefit
	<ul style="list-style-type: none"> <li>• Case Management</li> <li>• Chore Services</li> <li>• Consumer Directed Attendant Care</li> <li>• Emergency Response System</li> <li>• Home and Vehicle Modifications</li> <li>• Home Delivered Meals</li> <li>• Home Health Aide</li> <li>• Homemaker Services</li> <li>• Mental Health Outreach</li> <li>• Nursing Care</li> <li>• Nutritional Counseling</li> <li>• Respite</li> <li>• Senior Companions</li> <li>• Transportation</li> <li>• Consumer Choices Option</li> </ul>
Health And Disability	<ul style="list-style-type: none"> <li>• Adult Day Care</li> <li>• Consumer Directed Attendant Care</li> <li>• Counseling Services</li> <li>• Home and Vehicle Modification</li> <li>• Home-Delivered Meals</li> <li>• Home Health Aide</li> <li>• Homemaker</li> <li>• Interim Medical Monitoring and Treatment</li> <li>• Nursing</li> <li>• Nutritional Counseling</li> <li>• Personal Emergency Response System</li> <li>• Respite</li> <li>• Consumer Choices Option</li> </ul>
Intellectual Disability	<ul style="list-style-type: none"> <li>• Adult Day Care</li> <li>• Consumer Directed Attendant Care (CDAC)</li> <li>• Day Habilitation</li> <li>• Home and Vehicle Modifications</li> <li>• Home Health Aide</li> <li>• Interim Medical Monitoring and Treatment</li> <li>• Nursing</li> <li>• Personal Emergency Response System</li> <li>• Prevocational</li> <li>• Respite</li> <li>• Supported Community Living</li> <li>• Supported Community Living-Residential Based</li> <li>• Supported Employment</li> <li>• Transportation</li> <li>• Consumer Choices Option</li> </ul>
Physical Disability	<ul style="list-style-type: none"> <li>• Consumer Directed Attendant Care</li> <li>• Home and Vehicle Modification</li> <li>• Personal Emergency Response</li> <li>• Specialized Medical Equipment</li> <li>• Transportation</li> <li>• Consumer Choices Option</li> </ul>

## Summary of General Parameters

Below provides a summary of common criteria for waivers. Limitations, member eligibility and specifics vary by type of waiver. For the most comprehensive and current information, reference the Iowa HCBS provider manual at:

<https://dhs.iowa.gov/sites/default/files/HCBS.pdf>

All members will have a service plan developed by a DHS service worker or case manager in cooperation with the member. This plan must be completed, signed and dated prior to implementation of services. The service plan for members aged 20 or under must be developed or reviewed taking into consideration those services that may be provided through the individual education plan (IEP) and Early Periodic Screening, Diagnosis and Treatment (EPSDT or Care For Kids) plan(s).

- Members shall access all other services for which they are eligible and which are appropriate to meet their needs as a precondition of eligibility for the Waiver.
- A service plan must be developed and reviewed annually with the interdisciplinary team and signed and dated by the DHS service worker case manager.
- The member must choose HCBS services as an alternative to institutional services.
- In order to receive Waiver services, an approved Waiver service provider must be available to provide those services.
- Waiver services cannot be provided when the member is an inpatient of a medical institution.
- Members must need and use one of the available Waiver services during each quarter of the calendar year.
- A designated number of members (payment slots) are designated to be served under the HCBS program.
- A Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service.
- The combined total cost of a waiver services and Medicaid services shall not exceed the average cost of the member's level of care provided in a medical institution.
- Waiver services are available to both children and adults.
- Following is the hierarchy for accessing waiver services:
  1. Private insurance
  2. Medicaid and/or EPSDT (Care For Kids)
  3. Waiver services In Home Health Related Care
- In addition to services available through Waiver assistance may be available through the In-Home Health Related Care program and or the Rent Subsidy Program through the Iowa Finance Authority. Members may contact the Iowa Finance Authority at 1-800-432-7230.

## Newborn and Mothers Health Services

AmeriHealth Caritas Iowa shall not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother makes the decision to discharge the mother or the newborn child before that time. A participating provider is not required to obtain prior authorization for stays up to the forty-eight (48) or ninety-six (96) hour periods.

## Expanded Services

The following expanded care services are covered for eligible members in the AmeriHealth Caritas Iowa benefit package:

### Member Programs

- BrightStart® Maternity Program
- Lose to Win
- Focus on Fitness - Gym Membership
- Weight Watchers
- Nutritional Counseling with case management referral
- Smoking Cessation Program
- Mission GED

### Value Added Services

- The AmeriHealth Caritas CARE Card (Member incentive program)
- Telehealth Services and Tele-monitoring
- Care Coordination Management
- Mobile Health Units
- Member contact via mobile app, e-mail and text.
- Free cell phones – for eligible members to stay connected to their case. Must meet federal eligibility guidelines

## Emergency Services

Members requiring emergency care should be advised to call 911 if they are unable to transport themselves to the Emergency room.

AmeriHealth Caritas Iowa ensures the availability of emergency services and care **24 hours a day, 7 days a week** and is responsible for coverage and payment of emergency and post-stabilization care services regardless of whether the provider who furnishes the services has a contract with AmeriHealth Caritas Iowa. Post-stabilization services remain covered until AmeriHealth Caritas Iowa contacts the emergency room and takes responsibility for the member.

AmeriHealth Caritas Iowa will not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulted in serious impairment to bodily functions, or resulted in serious dysfunction of any bodily organ or part.

AmeriHealth Caritas Iowa will not refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the member's primary care provider, AmeriHealth Caritas Iowa, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Any provider of emergency services who does not have a contract in effect with AmeriHealth Caritas Iowa, and establishes payment amounts for services furnished to a member, must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that the provider could collect if the member received medical assistance under Title XIX or Title XXI through an arrangement other than enrollment in AmeriHealth Caritas Iowa.

**Definitions and requirements regarding urgent/emergent care are as follows:**

**Emergency Medical Condition.** A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part.

**Emergency Services.** Covered inpatient and outpatient services that are as follows: (i) furnished by a provider that is qualified to furnish these services; and (ii) needed to evaluate or stabilize an emergency medical condition.

**Emergent Care.** Means the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention (441 Iowa Administrative Code § 88.21)

**Urgent, Nonemergency Need.** The existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

**Non-Emergent Emergency Room Visits – Member Copays**

AmeriHealth Caritas will implement co-pays for non-emergent Emergency Room Visits for the Iowa Wellness Plan and hawk-i populations:

- Iowa Wellness Plan: \$8.00/per visit
- Iowa Hawk-I: \$25.00/visit

**A copayment shall not be imposed on hawk-i members whose family income is less than one-hundred and fifty percent (150%) of the federal poverty level.**

**AmeriHealth Caritas Iowa will ensure co-payments are not imposed for the following populations:**

**Exempt Populations**

Individuals between ages one (1) and eighteen (18), eligible under 42 C.F.R. § 435.118;
Individuals under age one (1), eligible under 42 C.F.R. § 435.118;
Disabled or blind individuals under age eighteen (18) eligible under 42 C.F.R. § 435.120 or 42 C.F.R. § 435.130;
Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age;
Disabled children eligible for Medicaid under the Family Opportunity Act;
Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends;
Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs;
An individual receiving hospice care, as defined in Section 1905(o) of the Social Security Act;
An Indian (as defined at 42 C.F.R. § 447.51) who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services; and
Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 C.F.R. § 435.213.

## Exempt Services

AmeriHealth Caritas Iowa will ensure co-payments are not imposed for the following services:

Preventive services provided to children under age eighteen (18)
Pregnancy-related services, including those defined at 42 C.F.R. § 440.210(a)(2) and 440.250(p) and counseling for cessation of tobacco use
Provider preventable services as defined at 42 C.F.R. § 447.26(b)
Family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act.

## Emergency Room Instructions Regarding Copays

Hospitals should be aware that before they provide non-emergency treatment and impose copays, the hospital must:

- Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

- Provide the individual with the name and location of an available and accessible alternative non-emergency services provider. If geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed;
- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount. The assessment of access to timely services shall be based on the medical needs of the enrollee; and
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

### Member Inability to Pay the Co-payment

Members can assert to providers that they are unable to pay the copayment. **Providers may not deny care or services to any member because of his or her inability to pay the copayment.** Members should be advised to contact AmeriHealth Caritas Iowa Member's services at 1-855-332-2440 (TTY: 1-844-214-2471) if they are denied treatment due to their inability to pay the co-payment.

Member's total cost sharing shall not exceed five percent (5%) of their quarterly household income. When cost sharing exceeds 5% of quarterly household income, cost sharing will no longer be collected. The provider's reimbursement will be adjusted accordingly; that is, any co-payment amounts will no longer be deducted from claims reimbursement.

### Out-of-Network Use of Non-Emergency Services

AmeriHealth Caritas Iowa will provide timely approval or denial of requests for authorization of out-of-network service(s) through the assignment of a prior authorization number, which refers to and documents the determination. Written follow-up documentation of the determination will be provided to the out-of-network provider within one business day after the decision. The member will be liable for the cost of unauthorized use of covered services from nonparticipating providers.

### Native American Services – In and Out of Network

AmeriHealth Caritas Iowa will provide Indian tribe, tribal organization and urban Indian organization (I/T/U) providers, whether they are participating in the network or not, payment for services in the basic benefits package provided to Indian members who are eligible to receive services from such providers:

- At a rate negotiated between the plan and the I/T/U provider; or
- If there is not a negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

AmeriHealth Caritas Iowa will make prompt payment to all I/T/U providers under federal regulations at 42 CFR sections 447.45 and 447.46.

### Non-Covered Services

AmeriHealth Caritas Iowa will refer members to local resources for services that are not covered by the Plan, as appropriate. Providers may contact the Rapid Response team at **1-855-332-2440, prompt #3** for assistance with coordination of non-covered services.

## Policies

### Private Pay for Non-Covered Services

Providers are required to inform Medicaid members about the costs associated with services that are not covered under AmeriHealth Caritas Iowa, prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement; the provider must obtain a signed document from the member to validate the private payment arrangement.

### Inpatient at Time of Enrollment

The managed care plan responsible for a member's inpatient care depends upon the timing of the member's Medicaid enrollment. Acute inpatient hospital services for members who are hospitalized at the time of disenrollment from a managed care plan shall be paid by that managed care plan until the member is discharged from acute care or for sixty (60) days after disenrollment, whichever is less, unless the member is no longer eligible for Medicaid. Services other than inpatient hospital services (e.g., physician services) shall be paid by the new managed care plan as of the effective date of enrollment in the new plan.

### Sterilizations

Providers must submit the appropriate consent form at the same time as the claims submission for these services. Sterilizations are not covered for members less than 21 years of age.

### Preventive Care/Immunizations

Preventive care includes a broad range of services (including screening tests, counseling, and immunizations/vaccines).

- Providers are required to administer immunizations in accordance with the recommended childhood immunization schedule for the United States, or when medically necessary for the member's health.
- Providers are required to prepare for the simultaneous administration of all vaccines for which a member under the age of 21 is eligible at the time of each visit.
- Providers are required to participate in the Vaccines for Children Program (VFC).

AmeriHealth Caritas Iowa has adopted the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services [childhood and adolescent immunization schedule approved by: the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP)], and the adult immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP).

### Immunization Schedules (Childhood, Adolescent and Adult)

- Visit the Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/vaccines/recs/schedules/default.htm> for recommended vaccines and immunizations.
- Visit <http://www.uspreventiveservicestaskforce.org/uspsttopics.htm> for the *Guide to Clinical Preventive Services* for recommendations made by the USPSTF for clinical preventive services.

### Vaccines for Children Program

Vaccines for members age 18 years and younger should be obtained through the Vaccines for Children Program (VFC). Vaccinations covered by the VFC program will not be reimbursed by AmeriHealth Caritas Iowa. Providers are expected to plan for a sufficient supply of vaccines and are required to report the use of VFC vaccines immunizations by billing with the appropriate procedure codes and modifier.



## Preventive Services and EPSDT

Our Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of members from birth to under age 21 by increasing adherence to Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines through identification of growth and development needs and coordination of appropriate health care services. Iowa's EPSDT program is referred to as "Care for Kids."

All Plan PCPs are responsible to provide EPSDT services to members from birth to under age 21 according to the Iowa Care for Kids Periodicity Schedule or upon request at other times in order to determine the existence of a physical or mental condition. The most current periodicity schedules are available on the AmeriHealth Caritas Iowa website at [www.amerhealthcaritasIA.com](http://www.amerhealthcaritasIA.com).

For the initial examination and assessment of a child, PCPs are required to perform the relevant EPSDT screenings and services, as well as any additional assessment, using the appropriate tools to determine whether or not a child has special health care needs.

Periodic assessments must consist of the following components:

- health history
- physical exam
- growth and development assessment
- vision and hearing screening
- dental screening and education
- immunizations
- developmental/behavioral screening
- nutrition assessment and education
- laboratory tests including blood lead testing
- anticipatory guidance
- referral for further diagnostic and treatment services, if needed

EPSDT providers (PCPs) are expected to provide written and verbal explanation of EPSDT services to Plan members including pregnant women, parent(s) and/or guardian(s), child custodians and sui juris teenagers. This explanation of EPSDT services should occur on the member's first visit and quarterly thereafter, and must include distribution of appropriate EPSDT educational tools and materials.

## Screening Timeframes

EPSDT providers (PCPs) are contractually obligated to provide EPSDT screenings within 30 days of the scheduled due date for children under the age of two years and within 60 days of the scheduled due date for children age two and older.

Initial EPSDT screenings must be offered to new members within 60 days of becoming an AmeriHealth Caritas Iowa member, or at an earlier time if needed to comply with the periodicity schedule. At the latest, the initial EPSDT screening must be completed within three months of the member's enrollment date with AmeriHealth Caritas Iowa. Periodic EPSDT screenings must occur within 30 days of the request.

Plan PCPs are expected to assist members with accessing substance abuse and mental health services, as needed. The Plan's Rapid Response team is also available to members and providers to support care coordination and access to services. Members and providers may request Rapid Response support by calling 1-855-332-2440, prompt #3.

## Pharmacy Services

Pharmacy services covered by AmeriHealth Caritas Iowa are managed by the Plan's delegated vendor, PerformRx. For more information on the provision of pharmacy services or to view the searchable and



printable Drug Formulary, please visit [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com). For questions regarding pharmacy services, Plan members and providers may contact:

PerformRx Iowa Members Services: **1-855-248-0453**

PerformRx Iowa Providers Services: **1-855-328-1612**

PerformRx TTY: **1-855-205-0983**

### Formulary

AmeriHealth Caritas Iowa's drug benefit has been developed to cover medically necessary prescription products. The pharmacy benefit design provides for outpatient prescription services that are appropriate, Medically Necessary, and are not likely to result in adverse medical outcomes.

The most up-to-date Formulary is available online in the Provider Center at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com).

### Prior Authorization

The Pharmacy Services Department at AmeriHealth Caritas Iowa issues Prior Authorizations to allow processing of prescription Claims not listed on the Formulary. Call **1-855-328-1612** between 7:30 a.m. and 6:00 p.m. Monday through Friday (CST);

- After business hours, Saturday, Sunday and Holidays, call the Member Services at **1-855-248-0453**.

### The Prior Authorization procedure is as follows:

The prescriber contacts AmeriHealth Caritas Iowa by:

1. Web submission under Pharmacy Services [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com) or
2. Telephone **1-855-328-1612** or
3. Fax: **1-855-825-2714**

Member Services may be contacted for clinical issues after business hours, Saturdays, Sundays, and Holidays by telephone at **1-855-248-0453**.

All prior authorization requests will be processed within 24 hours

### Pharmacy Copay

\$3.00 co-pay will be implemented on brand name Prescriptions for eligible Iowa Wellness plan enrollees. Exemptions will include chronic conditions such as: Asthma, Cancer, Diabetes, Epilepsy, Glaucoma, Heart Disease, High Blood Pressure, HIV/AIDS, Immunizations, Mental Health (except controlled substances used for anxiety) and Parkinson's.

Exempt populations:

- Individuals between ages one (1) and eighteen (18), eligible under 42 C.F.R. § 435.118; Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends;

### Emergency Supply

In the event a member needs to begin therapy with a non-covered medication before prior authorization can be obtained, pharmacies are authorized to dispense up to a 72 hour emergency supply"

- The Plan will allow a one time by generic code number for a 3 day temporary supply at the highest priority.
- The temp supply code will be 333
- The copay for temp supplies should be \$0 for all drugs
- The free form message with the temporary supply code will return to the pharmacy
- Once the member utilizes the onetime temp supply, the member would require a prior authorization.
- 1 emergency fill per Generic code number per rolling 90 days.

## Transition Supply

New members to the Plan are eligible for a transition supply of non-formulary medications during their first 60 days of enrollment with the Plan.

## Over-the-Counter Medications

Certain generic over-the-counter medications are covered by AmeriHealth Caritas Iowa with a prescription from the prescribing physician. These include, but are not limited to, aspirin, acetaminophen, ibuprofen, cough and cold preparations, tobacco cessation products and antihistamines.

## Pharmacy Lock-In Program

To support the reduction of fraud, waste and abuse within the Medicaid system, AmeriHealth Caritas Iowa utilizes a recipient restriction (lock-in) program to identify members who have misused, abused or committed possible fraud in relation to the receipt of pharmacy services. Under this program, a multidisciplinary team uses established procedures to review member medical/pharmacy utilization for the purpose of identifying misuse, abuse or potential fraud. A member may be identified for review when any of the following criteria is met:

- Total pharmacy prescription costs (all prescriptions) greater than \$300 per month
- Member gets prescriptions filled at more than two (2) pharmacy locations within one month
- Member has prescriptions written by more than two (2) physicians per month
- Polypharmacy or more than eight (8) therapeutic agents per month
- Member fills prescriptions for more than three (3) controlled substances per month
- Member obtains refills (especially on controlled substances) before recommended days supply is exhausted
- Duration of narcotic therapy is more than 30 consecutive days without an appropriate diagnosis
- Number of prescriptions for controlled substances is more than 15 percent of the total number of prescriptions
- Prescribed dose outside recommended therapeutic range
- Same/similar therapy prescribed by different prescribers
- No match between therapeutic agent and specialty of prescriber
- Fraudulent activities (forged/altered prescriptions or borrowed cards)
- More than three (3) admissions to more than one (1) hospital in any 90 days in the past six (6) months
- More than three (3) emergency room visits within 90 days with little or no PCP intervention or follow-up
- Same/similar services or procedures in an outpatient setting within one year

AmeriHealth Caritas Iowa accepts referrals of suspected fraud, misuse or abuse from a number of sources, including physician/pharmacy providers, the Plan's Pharmacy Services department, Member/Provider Services, the Special Investigations Unit, Case Management/Care Coordination,

Special Care Unit, Quality Management, Medical Affairs and the Iowa DHS. If you suspect member fraud, misuse or abuse of services, you are encouraged to make a referral to the Pharmacy Lock-In Program by calling the Fraud and Abuse Hotline at 1-866-833-9718.

All referrals are reviewed for potential restriction. If the results of the review indicate misuse, abuse or fraud, AmeriHealth Caritas Iowa will place the member in the Pharmacy Lock-In Program, which means the member(s) can be restricted to one PCP and/or one pharmacy.

If a member is placed in the Pharmacy Lock-In Program, the member's assigned PCP will receive a letter from AmeriHealth Caritas Iowa identifying the restricted member by name and ID number, and, as appropriate, the pharmacy where the member must receive his/her prescription medications.

## Vision Services

### Comprehensive Eye Care Administrator

AmeriHealth Caritas Iowa's routine vision, eye wear and eye medical/surgical benefits are administered through Avesis. Inquiries regarding these benefits should be directed to the Avesis at 800-952-6674 or you may visit their web site at [www.avesis.com](http://www.avesis.com).

## Laboratory Services

In an effort to provide high quality laboratory services in a managed care environment for our members, AmeriHealth Caritas Iowa has made agreements with the following laboratories:

Laboratory	Type	Phone	Website
Quest Diagnostic LLC	General Lab Services	See website <Insert Phone>	<a href="http://www.questdiagnostics.com">www.questdiagnostics.com</a>
Drugscan	Specialty Lab Services	1-800-235-4890	<a href="http://www.drugscan.com">www.drugscan.com</a>
Essential Testing	Specialty Lab Services	<Insert Phon1-618-623-0623e>	<a href="http://www.etlab.org">www.etlab.org</a>

To quickly establish an account with one or more of these labs please call the numbers listed above. For more information about individual labs, please visit their website.

- Network Physicians are encouraged to perform venipuncture in their office whenever possible. Providers should contact the laboratory provider in question to arrange a pick-up service.
- AmeriHealth Caritas Iowa highly recommends that pre-admission laboratory testing be completed by the PCP. However, testing can be completed at the hospital where the procedure will take place, and does not require a referral from AmeriHealth Caritas Iowa.
- **STAT labs must only be utilized for urgent problems.** The ordering physician may give the member a prescription form or AmeriHealth Caritas Iowa procedure confirmation form to present to the participating facility.

## Support Services

- Interpretation and translation services and services for the hearing and visually impaired are free to AmeriHealth Caritas Iowa members. To access any of these services, members may contact Member Services toll-free at 1-855-332-2440 or TTY at 1-844-214-2471.

## **SECTION IV**

# **Medical Management Programs**

## IV. Medical Management Programs

The following information is in regard to AmeriHealth Caritas Iowa's Integrated Health Care Management (IHCM) and Medical Management programs, which includes Case & Disease Management and Care Coordination for physical and mental health services provided to Plan members.

### Integrated Health Care Management Overview

The Plan's Integrated Health Care Management (IHCM) program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This fully integrated model allows members to move seamlessly from one component to another, depending on their unique needs. From this integrated solution the Plan delivers and coordinates care across all programs.

The IHCM program includes assessment, treatment and other care planning, as well as service coordination with IDEA, substance use disorder providers, LTSS providers, and other community resources. The IHCM program also incorporates health and illness self-management education. The program is structured around a member-based decision support system that drives both communication and Member-centered care plan development through a multidisciplinary approach to management. The IHCM process also includes reassessing and adjusting the Member Centered Care Plan and its goals as needed.

AmeriHealth Caritas Iowa's IHCM team includes nurses, social workers, Care Connectors, clinical pharmacists, Plan medical directors, primary care providers (PCPs), specialists, members and caregivers, parents or guardians. This team works to meet our members' needs at all levels in a proactive manner that is designed to maximize health outcomes.

### Integrated Health Care Management Components

There are six core components to our Integrated Health Care Management (IHCM) Program:

- Pediatric Preventive Health Care
- Bright Start® (Maternity Management)
- Rapid Response
- Episodic Care Management (ECM)
- Complex Care Management (CCM)
- Community Care Management Team (CCMT)

#### Pediatric Preventive Health Care – Care for Kids

This program is designed to improve the health of members under the age of 21 years by increasing adherence to Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines. This is accomplished by identifying and coordinating preventive services for these members. Program approach combines scheduled member outreach and point-of-contact notification for Plan staff and providers when a member is due or overdue for an EPSDT service.

#### Bright Start® (Maternity Management)

This program is designed to assist expectant mothers by promoting healthy behaviors and controlling risk factors during pregnancy. The program is based on the Prenatal Care Guidelines from the American College of Obstetricians and Gynecologists (ACOG). As pregnant members are identified by new member assessments, claims data, routine member outreach and provider reporting, Plan staff work to ensure that each pregnant member is aware of the services and support offered through the Bright Start® program.

Under this program and state guidelines, prenatal care providers are expected to complete the Iowa Integrated Screen to assess risk for each expectant mother. The completed screening tool must be submitted to the Plan as part of the authorization for obstetric services.

It is the provider's responsibility to address identified risk factors upon contact with the member and to develop appropriate action items in collaboration with the member to resolve the identified risks.

### **Rapid Response**

This team is designed to address the needs of members and to support providers and their staff. The team is composed of non-clinical Care Connectors. This team performs three functions on behalf of Plan members and providers: receiving inbound calls, conducting outbound outreach activities and providing care coordination support.

Members and providers may request Rapid Response support by calling **1-855-332-2440, prompt #3**.

### **Episodic Care Management (ECM)**

This program coordinates services for new adult and pediatric members, as well as existing members, with short-term and/or intermittent needs. Members in this program typically have singular issues and/or comorbidities. Program staff includes Care Managers with RN or MSW designations. Program staff support members by providing resolution for issues relating to access and care coordination. Program staff also provide member-centered plan of care support by performing comprehensive member assessments, addressing short- and long-term member goals and developing a member-centered plan of care in collaboration with the member, member caregiver(s) and the member's physician(s).

### **Complex Care Management (CCM)**

This program serves members identified as needing comprehensive and disease-specific assessments, and re-assessments, along with the development of short- and long-term goals and a member-centered plan of care, developed in collaboration with the member, the member's caregiver(s) and the member's physician(s). Program staff includes Care Managers with RN or MSW designations.

Members in the Complex Care Management program are screened for the following as part of standard protocol:

- All members receive a comprehensive initial assessment that meets NCQA requirements.
- Adult members and children ages 13 through 17 receive a depression screening to assess their severity of depression. Based on the results the member receives education and referral to appropriate behavioral health resources.
- Adult members receive a Quality of Life screening and rescreening.
- Subsequent detailed reassessments are performed for any item that screens positive in the initial assessment.

### **Community Care Management Team**

Members who fit the classification of "super utilizer", based on a history of or a risk for a disproportionate utilization of services and cost, are targeted for engagement by a Community Care Management Team member. Most individuals receiving Home and Community-based Services will fall into this category of "high risk".

Members in this program receive:

- High touch, face-to-face engagement
- Assistance with navigating and increasing their access to needed medical, behavioral health and social services
- A member-centered plan of care involving the member, member's caregiver(s), community based services and physicians



## Program Participation

Participation in the IHCM program is offered to all Plan members, with the ability for members to opt out upon request. Members may also self-refer into a program by contacting the Plan.

Members are initially identified for specific IHCM needs upon joining the Plan. Through material and telephonic outreach, members are encouraged to let the Plan know if they have a chronic condition, special health need or if they are receiving on-going care. A new member assessment is included in the members' welcome packet to identify current health conditions and health care services. Based upon their responses to the initial health assessment, members are identified for participation in the appropriate care management program.

### “Let Us Know” Program

Providers are encouraged to refer members to the IHCM program as needs arise or are identified through our “Let Us Know” program. If you recognize a member with a special, chronic or complex condition who may need the support of one of our programs, please contact the Rapid Response team at **1-855-332-2440, prompt #3**. Providers can also complete a “Let Us Know” intervention form and fax to our Rapid Response fax line for members that have missed appointments, need transportation services, or further education on their treatment plan or chronic condition. This form can be downloaded from our website at [www.amerihealthcaritasia.com](http://www.amerihealthcaritasia.com).

Members are also referred to the IHCM program through internal Plan processes. Identified issues and diagnoses that result in a referral to the IHCM program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses)
- Risk score indicating over- or under-utilization of care and services
- Pediatric members requiring assistance with EPSDT and/or IDEA services
- Pediatric members in foster care or receiving adoption assistance
- Infants receiving care in the NICU
- Members with dual medical and behavioral health needs
- Members with substance abuse-related conditions
- Members who are developmentally or cognitively challenged
- Members with a special health care need
- Pregnant members
- Members in need of long term services and supports to avoid hospital or institutional admission
- Members with chronic conditions or diseases, including:
  - Heart failure
  - CVD
  - Diabetes
  - Asthma (including pediatric asthma)
  - Chronic obstructive pulmonary disease (COPD)
  - Sickle cell
  - Hypertension
  - HIV/AIDS
  - Cancer

### Care Coordination with the PCP

AmeriHealth Caritas Iowa recognizes that the PCP is the cornerstone of the member's care coordination and delivery system. Our care management staff contacts each PCP during a member's initial enrollment into the chronic care management program, as part of the comprehensive assessment and member-centered plan of care development process. Program staff creates the member's member-centered plan of

care using the PCP's plan as a foundation. Through this approach, program staff complements the PCP's recommendations in the development of an enhanced and holistic plan of care specific to chronic care management. The Care Manager remains in close communication with the PCP during the implementation of the plan of care, should issues or new concerns arise.

## Care Coordination with Other Providers

Program staff also contacts the member's key and/or current providers of care, as well as the member's behavioral health care providers, to determine the best process to support the member. This process eliminates redundancies and supports efficiencies for both programs. Program staff also engages key providers to be part of the development of the member-centered plan of care. As the member is reassessed, a copy of the care plan goals is supplied to both the provider and member.

## Integrating Behavioral and Physical Health Care

Members with behavioral health disorders often experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. AmeriHealth Caritas Iowa understands that coordination of care for these members is imperative. To meet this need, AmeriHealth Caritas Iowa has a fully integrated medical management department. Under this collaboration, the Plan's integrated platform will seamlessly coordinate member care across the physical and behavioral health and social service areas.

Plan staff will work with the appropriate primary care and behavioral health providers to develop an integrated plan of care for members in need of physical and behavioral health care coordination. Care Managers will also assure that communication between the two disciplines, providers and organizations, occurs routinely for all members with physical and behavioral health issues. Care Managers will also work to coordinate with substance use disorder providers and community resources, as appropriate. Care Managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning and provider-to-provider communication to ensure that member needs are continuously reviewed assessed and updated.

## Member-Centered Plan of Care

Through the Integrated Health Care Management program, AmeriHealth Caritas Iowa works with practitioners, members, and outside agencies to develop member-centered plan of care for members with special or complex health care needs. AmeriHealth Caritas Iowa's plan of care specifies mutually agreed-upon goals, medically-necessary services, behavioral health and alcohol and drug abuse services (as shared with the member's consent), as well as any support services necessary to carry out or maintain the plan of care, and planned care coordination activities. Member-centered plan of care also take into account the cultural values and any special communication needs of the member, family and/or the child.

AmeriHealth Caritas Iowa care planning is based upon a comprehensive assessment of each member's condition and needs. Each member's care is appropriately planned with active involvement and informed consent of the member, and his or her family or caregiver, as clinically appropriate and legally permissible, and as determined by the member's practitioner and standards of practice.

AmeriHealth Caritas Iowa also utilizes EPSDT guidelines in the development of Treatment Plans for members under age 21. AmeriHealth Caritas Iowa works with practitioners to coordinate care with other treatment services provided by state agencies.

Through AmeriHealth Caritas Iowa's Integrated Health Care Management program, the member is assisted in accessing any support needed to maintain the plan of care. The Plan and the PCP are expected to jointly ensure that members and their families (as clinically appropriate) are fully informed of all

covered and non-covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. In order to make treatment decisions and give informed consent, available treatment for members will include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether AmeriHealth Caritas Iowa provides coverage for those treatments.

Member-centered plan of care for members with special health care needs are to be reviewed and updated every 12 months, at a minimum, or as determined by the member's PCP on the basis of the PCP's assessment of the member's health and developmental needs. The revised plan of care is expected to be incorporated into the member's medical record following each update.

## Coordinating Care through Transitions and Discharge Planning

One of the most important functions of a managed care organization is to assist in coordination of care during transitions. This includes, but is not limited to:

- Changes in care setting such as from hospital to home or hospital to nursing facility;
- Changes in health status due to presentation of a new chronic, sometimes life-threatening condition;
- Temporary or permanent changes in the fulcrum of care when a patient must change from a primary care physician to a specialist due to a surgical need or exacerbation of a chronic condition;
- Changes in a living situation to obtain more independence or because of a need for greater support; or
- Caregiver and family changes.

During transitions, members are supported through an AmeriHealth Caritas Iowa community-based care manager. In order for this to occur, providers who are involved in such transitions are required to cooperate. AmeriHealth Caritas Iowa care team staff will participate and cooperate in the care planning process. Documentation of the discharge plan for each member discharged from a hospital must be forwarded within twenty-four (24) hours and this must include the destination of the member upon discharge. For nursing facilities and intermediate care facilities (ICFs) AmeriHealth Caritas Iowa must be allowed to review the care plan to determine the adequacy and ensure timely discharge planning. These provisions are required in the contract with DHS.

## IDEA & Care Coordination for Children with Special Health Care Needs

The Individuals with Disabilities Education Act (IDEA), a federal law, passed in 1975 and reauthorized in 1990, mandates that all children receive a free, appropriate public education regardless of the level or severity of their disability. IDEA provides funds to enable states to provide a public education to students with disabilities. Under IDEA, students with disabilities are able to receive public education because the law provides for individualized education programs (IEP) that meet the unique needs in the least restrictive environment for each child in the IDEA program. The law also provides guidelines for determining what related services are necessary and outlines a "due process" procedure to make sure these needs are adequately met.

Children ages 3 to 21 who have been assessed as needing special education services because of a disabling condition are eligible for the program. Through the program, comprehensive evaluations are performed by a multidisciplinary professional team and shared with the parent, PCP, teachers and other stakeholders who are involved with the child's learning.

AmeriHealth Caritas Iowa is involved as a participant in the coordination of wrap-around services needed to support the child's educational process. The Plan notifies the PCP when a child receiving IDEA

services is identified. However, because school health personnel do not necessarily know AmeriHealth Caritas Iowa as the child's insurance carrier, the Plan is often placed in a position of not being aware of these children or their needs. Therefore, AmeriHealth Caritas Iowa also relies upon the practitioner to inform the Plan of children who are receiving special education services. The Plan's Care Connectors then work with the practitioner to obtain any services that are needed to support the educational process.

IDEA, Part B, specifically details eligibility criteria and services under the IDEA program that support an appropriate, free public education for this population. Practitioners are advised to contact AmeriHealth Caritas Iowa's Rapid Response team for assistance in obtaining support services for children receiving IDEA educational services.

IDEA, Part C, specifically details services for children from birth to three years who either have or are "at risk" for a developmental, educational, or behavioral or physical care delay. These children are likely not receiving special education services. Iowa Quality Infant and Toddlers program and AmeriHealth Caritas Iowa jointly monitor the progress of children who are eligible for IDEA Part C. Plan practitioners are asked to report any child they perceive may be eligible for services under this program.

AmeriHealth Caritas Iowa Care Connectors work with practitioners to obtain evaluative services for any child who has a screening procedure that indicates the potential need for services under IDEA.

Practitioners are expected to contact the Plan's Rapid Response team at **1-855-332-2440, prompt #3** to support coordination of services for children who are eligible or who have been identified as eligible for the IDEA education program.

## Identifying Children with Special Health Care Needs

PCPs are required to use a valid and standardized developmental screening tool to screen for developmental delays during well child visits or episodic care visits (stand-alone visits qualify as episodic visits). If a child is identified as having a delay that is significantly different than an expected variation, within the norm of age-appropriate development, the PCP is required to refer the child for a comprehensive developmental evaluation.

As a reminder, practitioners are expected to contact the Plan's Rapid Response team at 1-855-332-2440, prompt #3 to support coordination of services for children who may be eligible or who have been identified as eligible for the IDEA education program.

Once the need for evaluation is established, the evaluation appointment must be sought as soon as possible to meet federal guidelines on the timing of referral, evaluation, treatment planning and the initiation of rehabilitative service for children identified as having special needs.

Once the evaluation is completed, a multidisciplinary case meeting will be arranged, as appropriate, to discuss the findings and treatment recommendations. Upon the recommendations, the Care Connector and/or Care Manager will help to arrange services consistent with the treatment plan and as covered by AmeriHealth Caritas Iowa. For recommended services not covered by the Plan, the Care Connector will assist in locating services and assisting in coordination as needed.

After the initiation of recommended services, the provider and Care Manager should receive progress updates periodically. The Care Manager will work to assist the PCP with receiving regular progress updates. Progress monitoring continues until the child has demonstrated substantial progress and is released from the program.

Examples of children who may require a referral include, but are not limited to, those listed below:

- Children diagnosed with hyperactivity, attention deficit disorders, autism spectrum disorder, severe attachment disorders, or other behavioral disorders.

- Children with delay or abnormality in achieving emotional milestones, such as attachment, parent-child interaction, pleasurable interest in adults and peers, ability to communicate emotional needs, or ability to tolerate frustration.
- Children with persistent failure to initiate or respond to most social interactions.
- Children with fearfulness or other distress that does not respond to comforting by caregivers.
- Children with indiscriminate sociability, for example, excessive familiarity with relative strangers; or self-injurious or other aggressive behavior.
- Children who have experienced substantiated physical abuse, sexual abuse, or other environmental situations that raise significant concern regarding the children's emotional being

Examples of clinical conditions or environmental situations that warrant potential referral for evaluation:

#### **Clinical Conditions:**

- Chromosomal Abnormality or Genetic Disorder
- Metabolic Disorder
- Infectious Disease
- Neurological Disease
- Congenital Malformation
- Sensory Disorder (vision and hearing)
- Toxic Exposure
- ATOD (alcohol, tobacco, and other)
- Exposure to HIV

#### **Neonatal Conditions:**

- Birth weight 2000 grams - Infant's Birth weight less than 2000 grams.
- Premature birth – Gestational age less than or equal to 34 weeks.
- Respiratory Distress - Infant experienced respiratory distress requiring mechanical ventilation for more than 6 hours.
- Asphyxia -Infant experienced Asphyxia using APGAR score as an indicator.
- Hypoglycemia - Newborn has a serum glucose level less than 25 mg/dl.
- Hyperbilirubinemia - Newborn has had a bilirubin blood level of greater than 20 mg/dl
- Intracranial Hemorrhage - Newborn or infant has had a subdural, subarachnoid, intraparenchymal or intraventricular hemorrhage (grade II-IV).
- Neonatal Seizures Newborn or infant has had neonatal seizures.
- Major Congenital Abnormalities - Various genetic dysmorphic, or metabolic disorders; including anatomic malfunctions involving the head or neck (e.g., atypical appearance, including syndromal and non-syndromal abnormalities, overt or submucous cleft palate, morphological abnormalities of the pinna), Spina Bifida, congenital heart defects.
- Central Nervous System (CNS) Infection or trauma - Bacterial or viral infection of the brain, such as encephalitis or meningitis; or clinical evidence of central nervous system abnormality, abnormal muscle tone (persistent hypertonia or hypotonia), multiple apneic episodes inappropriate for gestational age, or inability to feed orally in a full-term infant or sustained in a premature infant.
- Congenital Acquired Infection - Congenital or prenatal acquired infection (i.e. cytomegalovirus, rubella, herpes, toxoplasmosis, HIV, syphilis).

#### **Post-Neonatal Conditions:**

- Suspected Visual Impairment - Infant is not able to make eye contact or to track visually after the first few weeks of life.

- Suspected Hearing Impairment - Infant 1) fails newborn hearing screen, 2) presents with unresolved otitis media, or 3) presents with physical abnormality of the ear or oral-facial anomalies.

#### **Newborn Situations:**

- Detailed pregnancy, labor, delivery and infant hospital stay history
- Delayed first well-care visit and/or delayed first immunization visit
- Frequently missed well care visits within the first year of life
- Expression of parental concern
- Suspicion of abuse/neglect

#### **Childhood Situations:**

- Frequently missed well care visits
- Expression of parental concern
- Screening failure demonstrated on administration of developmental assessment tool (Ages and Stages is recommended however practitioner's may use Denver Developmental Tool)
- Physical and/or laboratory results findings (example lead result >10 ng/dl)
- Inappropriate adaptation to school environment; schoolteacher or counselor expresses concerns about child's ability to adapt to school environment or learning
- Report/suspicion of abuse/neglect

#### **Adolescence Situations:**

- Expression of concern from child, parent, or school authority
- Behavioral risk assessment indication
- Failing grades or difficulty learning
- Demonstration of behavior significantly different from usual
- Report suspicion of abuse /neglect

Providers are encouraged to refer for further evaluation when any of the above conditions and/or situations, or other conditions and/or situations are present. Especially when the concern varies significantly from what is expected at the member's age or stage of development. If the provider detects what he or she considers a minor variation, the provider may use discretion in the timing of the referral. If the provider perceives that the area of concern may be due to a normal variation in development, the provider may choose to have the child return within a specified timeframe and re-administer the screening tool. However, when choosing to re-administer the screening, providers are expected to consider factors that may impact the child's return to the office:

- Reliability of the parent to return
- Transportation
- Competing priorities of parent that may prohibit return on the scheduled date
- Eligibility issues

### **Health & Lifestyle Education**

AmeriHealth Caritas Iowa PCPs are expected to provide Plan members with education and information about lifestyle choices and behaviors that promote and protect good health. AmeriHealth Caritas Iowa will support Plan providers in this effort by developing and distributing state-approved health education materials for Plan members, from time to time and as needed to address specific health education needs.

Additionally, AmeriHealth Caritas Iowa PCPs are expected to help educate Plan members regarding:



- Appropriate use of Urgent Care and Emergency Services, including how to access such care when necessary.
- How to access services such as vision care, behavioral health care and substance abuse services.
- Recommendations for self-management of health conditions and self-care strategies relevant to the member's age, culture and conditions.

## SECTION V UTILIZATION MANAGEMENT



## V. Utilization Management

The AmeriHealth Caritas Iowa Utilization Management (UM) program establishes a process for implementing and maintaining an effective, efficient utilization management system. Utilization Management activities are designed to assist our providers with the organization and delivery of appropriate health care services to members within the structure of the member's benefit plan. The Plan does not structure compensation to individuals or entities that conduct utilization management activities to incentivize the denial, limitation or discontinuation of medically necessary services to any member.

Per the provider agreement with AmeriHealth Caritas Iowa, providers are required to comply fully with the Plan's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service;
- Providing clinical information to support medical necessity when requested;
- Permitting access to the member's medical information;
- Involving the Plan's medical management nurse in discharge planning discussions and meetings;
- Providing a plan of treatment, progress notes and other clinical documentation as required.

### Prior Authorization

The most up-to-date list of services requiring prior authorization will be maintained in the provider area of our website at [www.amerhealthcaritasIA.com](http://www.amerhealthcaritasIA.com). The Plan's UM department hours of operation are 7:30 a.m. to 6:00 p.m. CST, Monday through Friday. The UM department can be reached at:

- UM Telephone: 1-844-411-0604.
- UM Fax: 1-844-211-0972
- BH UM Telephone: 1-844-214-2474
- BH UM Fax: 1-844-214-2469
- LTSS UM Telephone: 1-844-411-0604
- LTSS UM Fax: 1-844-411-0604

For prior authorizations after hours, call the **Nurse Call Line** at **1-855-216-6065**.

**Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas Iowa reserves the right to adjust any payment made following a review of the medical record and determination of the medical necessity of the services provided**

### Physical Health Services Requiring Prior Authorization

- All Waiver/Long Term Support Services
- All out of network services (with the exceptions noted below)
- All services that may be considered Experimental and/or Investigational
- Out of Network Specialty Visits
- Air Ambulance
- In-patient services
  - All inpatient hospital admissions, including medical, surgical and rehabilitation
  - Obstetrical Admissions/Newborn Deliveries exceeding 48 hours after vaginal delivery and 96 hours after caesarean section
  - In-patient Medical Detoxification
  - Elective transfers for inpatient and/or outpatient services between acute care facilities

- Long-Term Care Initial Placement if still enrolled with the plan
- Genetic Testing
- Home-based services
  - Home Health Care
  - Private duty nursing and personal care services if covered under benefit category
  - Skilled Nursing Visits (after 6 visits)
  - Enteral Feedings, including related DME
- Hospice Inpatient Services
- Termination of Pregnancy
  - Must meet indications based on Iowa DHS guidelines and requirements.
    1. The attending provider certifies in writing that continuing the pregnancy would endanger the life of the pregnant woman. Federal funding is available in these situations only if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
    2. The attending provider certifies in writing on the basis of the provider's professional judgment that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
    3. The pregnancy is the result of rape, that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 45 days of the date of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency must so certify in writing.
    4. The pregnancy is the result of incest, that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency or physician must so certify in writing.
- Therapy and related services
  - Speech Therapy, Occupational Therapy and Physical Therapy (after 12 visits for each modality)
  - Chiropractic Care
  - Cardiac Rehabilitation and Pulmonary Rehabilitation
- Transplants, including transplant evaluations
- All DME rentals
- Durable Medical Equipment (DME)
  - for billed charges \$ \$750 and over, including prosthetics and orthotics
  - Diapers/Pull-ups (ages 3 and above) who qualify:
    - for quantities over 300 per month
- The purchase of all motorized wheelchairs and all wheelchair components
- Hearing Services and Devices that exceed \$500 purchase price, may include but not limited to Hearing Aids, FM Systems, and Cochlear Implants/Devices
- Replacement of Hearing Aides that are less than 4 years old, except for children under 21
- Hyperbaric Oxygen
- Gastric Restrictive Procedure/Surgeries
- Surgical services that may be considered cosmetic, including
  - Blepharoplasty

- Mastectomy for Gynecomastia
- Mastopexy
- Maxillofacial
- Panniculectomy
- Penile Prosthesis
- Plastic Surgery/Cosmetic Dermatology
- Reduction Mammoplasty
- Septoplasty
- Inpatient Hysterectomies
- Elective Termination of Pregnancy
- Cochlear Implantation
- Pain Management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and nerve blocks performed in a Short Procedure Unit (SPU) or Ambulatory Surgery Center (either hospital based or free standing) and pain management services not on the Iowa MA Fee Schedule performed in a physician office
- Radiology Services
  - CT Scan
  - PET Scan
  - MRI
  - MRA
  - Nuclear Cardiac Imaging

#### All Waiver Services

- All unlisted and miscellaneous codes (including, but not limited, to codes ending in “99”)
- All services not listed on Iowa Medicaid Fee Schedule

### Physical Health Services that Do Not Require Prior Authorization

The following services will not require prior authorization from AmeriHealth Caritas Iowa:

- Emergency Room Services (in-network and out-of-network)
- 48-Hour Observations (except for Maternity – notification required)
- Low-level plain films - X-rays, EKG’s
- Family Planning Services
- Post Stabilization Services (in-network and out-of-network)
- EPDST Screening Services
- Women’s Healthcare by In-Network Providers (OB-GYN Services)
- Routine Vision Services
- Dialysis

### Physical Health Services that Require Notification

Providers will be asked to notify AmeriHealth Caritas Iowa when the following services are delivered:

- Maternity Obstetrical Services (after the first visit) and outpatient care (includes 48-Hour Observations)
- All newborn deliveries

## **Behavioral Health Services that Require Prior Authorization**

- All out of network services (with the exceptions noted above)
- Electroconvulsive Therapy (ECT)
- Psychiatric In-patient services
- Psychoanalysis
- Psychological, Neuropsychological, Developmental Testing
- Community Support Services
- Applied Behavior Analysis (ABA)
- Home & Community Based Waiver Services
- Behavioral Health Intervention Services
- Psychiatric Medical Institutions for Children (PMIC) Services
- Habilitation Program Services
- Intensive Psychiatric Rehabilitation Services (IPR)
- Assertive Community Treatment (ACT)
- Intensive In-Home Behavioral Health Services
- Mental Health Day Treatment
- Mental Health & Substance Use Disorder (SUD) Peer Support Services
- Substance Use Disorder (SUD) Residential Programs
  - Clinically Management Low Intensity
  - Clinically Management Medium Intensity
  - Medically Monitored Intensive Inpatient
  - Medically Managed Intensive Inpatient
- Substance Use Disorder (SUD) Intensive Outpatient Program (Level 2.1)
- Substance Use Disorder (SUD) Partial Hospitalization/Day Treatment Program (Level 2.5)

## **Behavioral Health Services that Do Not Require Authorization/Notification**

- 23-Hour Observations
- Behavioral Health & Substance Use Disorder (SUD) Evaluations & Assessments
- Behavioral Health & Substance Use Disorder (SUD) Medical Team Conference
- Behavioral Health & Substance Use Disorder (SUD) Medication Evaluation, Management & Consultation
- Behavioral Health & Substance Use Disorder (SUD) Outpatient Therapy (Individual, Family, Group Therapy Sessions )
- Behavioral Health & Substance Use Disorder (SUD) Therapeutic Injections
- Institute of Public Health (IDPH) Substance Use Disorder Services for all IDPH participants
- Mobile Counseling

## **Behavioral Health Services requiring Notification**

- Substance Use Disorder Acute Detoxification (notification within 24 hours of discharge)
- Substance Use Disorder Sub-acute Detoxification (notification within 24 hours of discharge)
- Crisis Intervention Mental Health and Substance Abuse Disorder (SUD) Services (notification and auto-approval)

## **LTSS Services requiring Prior Authorization**

- For enrollees residing in their own home, LTSS will be authorized/re-authorized every 90-days during the face-to-face on-going care management intervention.
- For enrollees residing in a LTSS Facility (NF, NFMI, ICF/ID, MHID): Unless otherwise noted, all LTSS will be authorized/re-authorized every 120-days during the face-to-face on-going care management intervention.
- Adult Day Health Care Services – authorization required after 1<sup>st</sup> visit and re-evaluate every 6 months.
- Home Care Training- authorization required after 1<sup>st</sup> visit
- Nursing Care, non-skilled- authorization for 25 visits in 60 days. Needs re-authorization every 60 days.
- Personal Care II Services - authorization required
  - For short term needs, i.e. immediate post op or post hospitalization needs, authorization for 30 days and care coordinator to re-evaluate
  - For long term needs, i.e. chronic ADL support, authorization for 3 months and care coordinator re-evaluates, sooner if clinically indicated
- Homemaker Services, for duties listed above- authorization required after the 1<sup>st</sup> visit and re-evaluate every 90-days
- Companion Care-authorization required after 1<sup>st</sup> visit and re-evaluate every 6 months

#### **LTSS Services that do not require Prior Authorization.**

- Personal Emergency Response System- No authorization required. Care coordinator to re-evaluate every 6 months
- Home Delivered Meals- No authorization required. Care coordinator to re-evaluate every 6 months
- Home Modifications or Non-ambulation Assistive Devices- Clinical evaluation of the home is required initially by Care coordinator or Occupational Therapist or Physical Therapist. No authorization for equipment is required. A prescription will need to be written by the PCP to supply to the DME provider. This includes: :
  - (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
  - (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
  - (3) Grab bars and handrails.
  - (4) Turnaround space adaptations.
  - (5) Ramps, lifts, and door, hall and window widening.
  - (6) Fire safety alarm equipment specific for disability.
  - (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
  - (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

### **Installation**

If the enrollee needs a DME item that requires installation; the care coordinator will pursue with the enrollee their various options and only using qualified providers.

Enrollees who are able to have their equipment installed will do so. The care coordinator will follow up with the enrollee to ensure the installation has occurred consideration to include; timely installation; quality installation; excellent customer service provided.

For enrollees who are unable to have the equipment installed, the care coordinator will select the provider and following consultation with the enrollee will schedule the installation at a time convenient for the enrollee. The care coordinator will follow up with the enrollee to ensure the installation has occurred consideration to include; timely installation; quality installation; excellent customer service provided.

**NOTE: A decision will be made once ALL requested/necessary materials have been received.**

### **Organization Determinations**

An organization determination is any determination (i.e. approval or denial) by AmeriHealth Caritas Iowa regarding the benefits a member is entitled to receive from the Plan. Examples include:

- Payment for emergency services, post-stabilization care or urgently needed services;
- Payment for any other health service furnished by a non-contracted provider and the member believes:
  - The services are covered under Medicaid program; or,
  - If not covered under the Medicaid program, should have been furnished, arranged for or reimbursed by AmeriHealth Caritas Iowa.

- Refusal to authorize, provide or pay for services – in whole or in part – including the type or level of services, which the member believes should be furnished, arranged for or reimbursed by the Plan.
- Reduction or premature discontinuation of a previously authorized on-going course of treatment; or,
- Failure of the Plan to approve, furnish, arrange for or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, if the delay adversely affects the health of the member.

The procedures for appealing an organization determination are described in the “Grievances, Appeals and Fair Hearings” section of this *Provider Manual*.

## Standard

AmeriHealth Caritas Iowa must notify the member of its determination as expeditiously as the member’s health condition requires, or no later than 7 calendar days after AmeriHealth Caritas Iowa receives the request.

The timeframe may be extended up to 14 additional calendar days if:

- The provider or the member requests an extension; and,
- The Plan justifies the need for additional information and the extension is in the member’s best interest.

## Expedited

The member’s physician may request an expedited determination, including authorizations, from AmeriHealth Caritas Iowa when the member or physician believes waiting for a decision under the standard timeframe could seriously jeopardize the member’s life, health or ability to regain maximum function.

In situations where a provider indicates or AmeriHealth Caritas Iowa determines that following the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function, AmeriHealth Caritas Iowa will make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later than three (3) business days after receipt of the request for service. AmeriHealth Caritas Iowa may extend the three (3) business days by up to fourteen (14) calendar days if the member or the provider requests an extension or the plan justifies a need (to the State agency, upon request ) for additional information and how the extension is in the best interest of the member. AmeriHealth Caritas Iowa will provide its justification to the DHS upon request. Unless otherwise provided by law, if the AmeriHealth Caritas Iowa fails to respond to a member’s prior authorization request within three (3) business days of receiving all necessary documentation, the authorization is deemed to be granted and notice shall be given. In accordance with 42 C.F.R. § 438.404(c)(1), if the plan intends to take an action to terminate, suspend, or reduce previously authorized Medicaid-covered services, AmeriHealth Caritas Iowa shall give notice of the adverse action at least 10 days before the date of action.

## Medical Necessity Services

“Medically Necessary” or “Medical Necessity” is defined as services or supplies that are needed for the diagnosis or treatment of the member’s medical condition according to accepted standards of medical practice. The need for the item or service must be clearly documented in the member’s medical record.

**Medically Necessary Services.** Those Covered Services that are, under the terms and conditions of the Contract, determined through AmeriHealth Caritas Iowa utilization management to be:



**For members ages 21 and older**, a service is medically necessary for individual if a physician or other treating health provider, exercising prudent clinical judgment, would provide or order the service for a patient for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms, and the provision of the service is:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;
2. Provided for the diagnosis or direct care and treatment of the condition of member enabling the member to make reasonable progress in treatment;
3. Within standards of professional practice and given at the appropriate time and in the appropriate setting;
4. Not primarily for the convenience of the member, the member's physician or other provider; and
5. The most appropriate level of Covered Services, which can safely be provided.

**For members under age twenty-one ( 21)**, a service is medically necessary if it promotes normal growth and development and prevents, diagnoses, detects, treats, ameliorates the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability. For this population, a service is medically necessary if it is:

- A recommended EPSDT screening service;
- An immunization recommended by the Advisory Committee on Immunization Practices (ACIP),
- A health care, diagnostic service, treatment, or other measure described in Section 1905(a) of the Social Security Act, 42 U.S.C. § 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid plan; or,
- A health care intervention that:
  - Assists in achieving, maintaining, or restoring health and functional capabilities without discrimination to the nature of a congenital/developmental abnormality;
  - Is appropriate for the age and developmental status of the child;
  - Takes into account the setting that is appropriate to the specific needs of the child and family; and,
  - Is reasonably expected to produce the intended results for children and to have expected benefits that outweigh potential harmful effects.

### Medical Necessity of Mental Health Services

Psychosocial services are those mental health services, not including outpatient, inpatient and medication management services, designed to support an individual with a serious mental illness or child with an SED to successfully live and work in the community. AmeriHealth Caritas has UM guidelines to interpret the psychosocial necessity of mental health services and supports. In the context of these guidelines, psychosocial necessity is an expansion of the concept of medical necessity and shall mean clinical, rehabilitative or supportive mental health services which meet all the following conditions:

- Are appropriate and necessary to the symptoms, diagnoses or treatment of a mental health diagnosis
- Are provided for the diagnosis or direct care and treatment of a mental disorder;
- Are within standards of good practice for mental health treatment;
- Are required to meet the mental health needs of the member and not primarily for the convenience of the member, the provider, or the AmeriHealth Caritas Iowa; and
- Is the most appropriate type of service which would reasonably meet the need of the member in the least costly manner.



- The determination of psychosocial necessity shall be made after consideration of:
- The member's clinical history including the impact of previous treatment and service interventions
- Services being provided concurrently by other delivery systems
- The potential for services/supports to avert the need for more intensive treatment
- The potential for services/supports to allow the member to maintain functioning improvement attained through previous treatment
- Unique circumstances which may impact the accessibility or appropriateness of particular services for an individual member (e.g., availability of transportation, lack of natural supports including a place to live); and
- The member's choice of provider or treatment location.

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate health care cannot be effectively furnished more economically or appropriately on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary or a covered service/benefit.

AmeriHealth Caritas Iowa uses the following medical necessity criteria as guidelines for determinations related to medical necessity:

- InterQual Level of Care Acute Adult Criteria.
- InterQual Level of Care Acute Pediatric Criteria.
- InterQual Level of Care Outpatient Rehabilitation and Chiropractic Criteria.
- InterQual Home Care Criteria.
- InterQual Care Planning Procedures Adult Criteria.
- InterQual Care Planning Procedures Pediatric Criteria.
- InterQual DME Criteria.
- InterQual Level of Care Rehabilitation Criteria.
- InterQual Level of Care Subacute and Skilled Nursing Facility Criteria.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Geriatric.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Adult.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Adolescent.
- InterQual Level of Care Criteria Behavioral Health Psychiatry Child.
- InterQual Level of Care Criteria Behavioral Health Residential & Community Based Treatment.
- American Society of Addiction Medicine (ASAM) Criteria.
- NIA Radiology Guidelines.
- AmeriHealth Caritas corporate clinical policies.
- Other program-specific criteria are based upon program requirements.

When applying these criteria, Plan staff also considers the individual member factors and the characteristics of the local health delivery system, including:

- Member Considerations
  - Age, comorbidities, complications, progress of treatment, psychosocial situation, home environment.
- Local Delivery System

- Availability of sub-acute care facilities or home care in the AmeriHealth Caritas Iowa service area for post-discharge support.
- AmeriHealth Caritas Iowa benefits for sub-acute care facilities or home care where needed.
- Ability of local hospitals to provide all recommended services within the estimated length of stay.

Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by the Plan's Medical Director or other designated practitioner under the clinical direction of the Regional Medical Director.

Medical Necessity decisions made by the Plan's Medical Director or designee are based on the above definition of medical necessity, in conjunction with the member's benefits, medical expertise, AmeriHealth Caritas Iowa medical necessity guidelines (as listed above), and/or published peer-review literature. At the discretion of the Plan's Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting practitioner/provider may provide input to the decision. The Plan's Medical Director or designee makes the final decision.

AmeriHealth Caritas Iowa will not retroactively deny reimbursement for a covered service provided to an eligible member by a provider who relied on written or oral authorization from AmeriHealth Caritas Iowa or an agent of the Plan, unless there was material misrepresentation or fraud in obtaining the authorization. Upon request by a member or practitioner/provider, the criteria used for medical necessity decision-making in general, or for a particular decision, is provided in writing by the Plan's Medical Director or designee. AmeriHealth Caritas Iowa will not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the diagnosis, type of illness or condition of the member.

The Utilization Management staff involved in medical necessity decisions is assessed annually for consistent application of review criteria. An action plan is created and implemented for any variances among staff outside of the specified range. Both clinical and non-clinical staff members are audited for adherence to policies and procedures.

## **SECTION VI**

# **Grievances, Appeals and Fair Hearings**

## VI. Grievances, Appeals and Fair Hearings

### Grievance Process

If a member has a concern or question regarding the health care services he/she has received under AmeriHealth Caritas Iowa, he/she should contact Member Services at the toll-free number on the back of the member ID card. A Member Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Member Service representative does not resolve the problem to the member's satisfaction, the member has the right to file a grievance.

A *grievance* expresses dissatisfaction about any matter other than an *action* by AmeriHealth Caritas Iowa. The member may file a grievance in writing or by telephone at the information below. It must be filed within 90 days from the date of the concern. It may be filed by the treating provider or primary care provider (or another authorized representative) on behalf of the member.

A grievance may be filed about issues such as the quality of the care the member receives from AmeriHealth Caritas Iowa or a provider, rudeness from a Plan employee or a provider's employee, a lack of respect for their rights by AmeriHealth Caritas Iowa or any service or item that did not meet accepted standards for health care during a course of treatment.

#### To file a grievance:

##### *Telephone To:*

Member Services: 1-855-332-2440

Member Services Hours of Operation: 24 hours per day, 7 days per week

##### *Write To:*

AmeriHealth Caritas Iowa  
Attn: Member Services Grievance Department  
P. O. Box 7116  
London, KY 40742

If the member needs assistance in filing his/her grievance or needs the help of an interpreter, the member may call Member Services and, if needed, interpretation services will be made available to the member free of charge.

AmeriHealth Caritas Iowa will send the member an acknowledgement letter within three business days of receiving the grievance. The Plan will send a decision letter within 30 days of receiving the request. In some cases, the Plan or the member may need additional time to obtain more information. The member may request up to 14 more days and the Plan may also have an additional 14 days if additional information is needed and the delay is in the member's best interest. If the Plan needs more time, the member will be informed of the reason for the extension in writing.

### Appeals Process

#### Notice of Action

If AmeriHealth Caritas Iowa decides to deny, reduce, limit, suspend, or terminate a service the member is receiving, or if the Plan fails to act in a timely manner, the member will receive a written "Notice of Action."

If the member does not agree with AmeriHealth Caritas Iowa's determination as outlined in the Notice of Action, he/she may file an appeal. The member may ask an "authorized representative" (i.e. his/her doctor, a family member or friend) to file the appeal for them. Or, the provider may file the appeal, with the member's written consent.

The member, or an authorized representative with written consent, may ask for a Fair Hearing after the appeals process has been exhausted. Additional information on requesting a Fair Hearing is available in this section of the *Provider Manual*.

### Standard Appeal

A standard appeal asks AmeriHealth Caritas Iowa to review a decision about the member's care. The member must file an appeal within 30 days of the date on the Notice of Action.

**To file an appeal**, the member or authorized representative may:

***Write To:***

AmeriHealth Caritas Iowa  
Attn: Member Advocate  
Member Appeals Department  
P. O. Box 7128  
London, KY 40742

***Telephone To:***

Provider Appeals (on behalf of a member and with written consent): 1-844-214-2473.

Member Services: 1-855-332-2440

Member Services Hours of Operation: 24 hours per day, 7 days per week

If the member or authorized representative files an appeal by telephone, he/she must also send the appeal in writing. The review begins the day the Plan receives the request. The Plan will send a written acknowledgement to the member within three business days of receipt of the appeal. The Plan has 45 calendar days after receiving the appeal, whether oral or written, to make a decision regarding the matter.

Before the Plan makes a decision, the member and/or the person helping the member with the appeal may give information to AmeriHealth Caritas Iowa. The new information may be in writing or in person.

In some cases, the Plan, or the member may need additional time to obtain more information. The member may request up to 14 more days and the Plan may also have an additional five days if additional information is needed and the delay is in the member's best interest. If the Plan needs more time, the member will be informed of the reason for the extension in writing.

The member may review his/her file any time while AmeriHealth Caritas Iowa is reviewing the appeal. The member and his/her authorized representative may look at the case file. The member's estate representative may review the file after the member's death. The file may have medical records and/or other papers.

AmeriHealth Caritas Iowa will send the member or his/her authorized representative a letter with the decision, explaining how AmeriHealth Caritas Iowa made its decision and the date the decision was made.

### Expedited Appeal

If the time for a standard resolution could jeopardize the member's life, health or ability to attain, maintain or regain function, a member, or his/her authorized representative may request an expedited appeal orally or in writing. **Note:** Expedited appeals are for health care services only – not denied claims.

**To request an expedited appeal**, the member or his/her authorized representative may call Member Services. The Plan will not take punitive action against a provider who either requests an expedited resolution or supports a member's appeal.

AmeriHealth Caritas Iowa will send a written decision for an expedited appeal within 3 business days and will make a reasonable effort to provide oral notice of the resolution. If the request for an expedited appeal is denied, the appeal will immediately be moved into the standard appeal timeframe of no longer than 45 calendar days and the member will be notified in writing within two business days of the expedited appeal request.

## Fair Hearing

The member or his/her authorized representative may seek a Fair Hearing after the appeals process has been exhausted, but the Fair Hearing must be requested within 90 days from the date of AmeriHealth Caritas's appeal decision.

Members have the right to self-representation or to be represented by a family caregiver, legal counsel or other representative during a Fair Hearing. Parties to the Fair Hearing are the Plan and the member or his/her authorized representative. A provider may also request a Fair Hearing on behalf of a member with the member's consent by written notice.

For appeals not resolved wholly in favor of the member, the written notice shall include the right to request a DHS Fair Hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The written notice shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the plan's action.

The DHS "*Appeal and Request for Hearing*" form is an option for submitting a request for an appeal and may be found on the DHS website: [dhs.iowa.gov/appeal](https://dhs.iowa.gov/appeal). As an alternative, a written request may be sent to:

Department of Human Services  
Appeals Section  
1305 E. Walnut St. 5<sup>th</sup> Floor  
Des Moines, IA 50319

**Telephone:** 1-515-281-3094  
**FAX:** 1-515-564-4044  
**E-mail:** [appeals@dhs.state.ia.us](mailto:appeals@dhs.state.ia.us)

## Continuation of Benefits

A member may continue to receive services while waiting for the AmeriHealth Caritas Iowa appeal or the Fair Hearing decision if **all** of the following apply:

- The appeal is filed on or before ten calendar days of the date of AmeriHealth Caritas Iowa's appeal decision, or the intended effective date of the proposed action, whichever is later.
- The appeal is related to reduction, suspension or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not ended.
- The member requested the services to continue.

The member's services continue to be covered until one of the following occurs:

- The member decides not to continue the appeal.

- Ten calendar days have passed, from the date of the notice of resolution of the appeal, unless the member has requested a Fair Hearing within that timeframe.
- The time covered by the authorization is ended or the limitations on the services are met.
- The Fair Hearing office issues a hearing decision adverse to the member.

The member may have to pay for the continued services if the final decision from the Fair Hearing is adverse to them. If the Fair Hearing officer agrees with the member, AmeriHealth Caritas Iowa will pay for the covered services that were rendered to the member while waiting for the decision. If the Fair Hearing officer agrees with the member and the member did not continue to receive covered services while waiting for the decision, AmeriHealth Caritas Iowa will issue an authorization for the covered services to restart as soon as possible and the Plan will pay for the covered services.

## Provider Administrative (or Medical) Appeals

Providers may call the Peer-to-Peer telephone line at **1-844-412-7887** to discuss a medical determination with a physician in the AmeriHealth Caritas Iowa Medical Management department. Providers must call within two business days of notification of the determination (or prior to the member's discharge from a facility when the determination applies to an inpatient case). A provider requesting an administrative or medical appeal, for the reversal of a medical denial, may also submit an appeal in writing to:

AmeriHealth Caritas Iowa  
Attn: Provider Appeals Department  
P.O. Box 7128  
London, KY 40742

As a reminder, a provider may also file an appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call the Provider Appeals telephone line at **1-844-214-2473**.

Note: The purpose of the appeals process is to address medical determinations regarding health care services. This process is not intended to address denied claims or other issues. For information on filing an informal provider complaint please refer to the "Provider and Network Information" section of this *Provider Manual*. For information on disputing a claim, please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual*.

## **Section VII**

# **Quality Assurance and Performance Improvement Program**



## VII. Quality Assurance and Performance Improvement Program

AmeriHealth Caritas Iowa's Quality Assurance and Performance Improvement (QAPI) program provides a framework for evaluating the delivery of health care and services provided to members. AmeriHealth Caritas leadership provides strategic direction for the QAPI program and retains ultimate responsibility for ensuring that the QAPI program is incorporated into the Plan's operations. Operational responsibility for the development, implementation, monitoring and evaluation of the QAPI program is delegated by AmeriHealth Caritas leadership through the regional president to the AmeriHealth Caritas Iowa Marketing President and Quality Assessment Performance Improvement Committee (QAPIC).

The purpose of the QAPI program is to provide a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Caritas Iowa members by providers.

The QAPI program also provides oversight and guidance for the following:

- Determining practice guidelines and standards by which the program's success will be measured.
- Complying with all applicable laws and regulatory requirements, including but not limited to applicable state and federal regulations and NCQA accreditation standards.
- Providing oversight of all delegated services.
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to members through the credentialing/re-credentialing process.
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement.
- Reducing health care disparities by measuring, analyzing and re-designing of services and programs to meet the health care needs of our diverse membership.

AmeriHealth Caritas Iowa develops goals and strategies considering applicable state and federal laws and regulations and other regulatory requirements, NCQA accreditation standards, evidence-based guidelines established by medical specialty boards and societies, public health goals and national medical criteria. The Plan also uses performance measures such as HEDIS®, CAHPS®, consumer and Provider surveys, and available results of the External Quality Review Organization (EQRO), as part of the activities of the QAPI program.

### Quality Assessment Performance Improvement Committee

The QAPIC oversees AmeriHealth Caritas Iowa's efforts to measure, manage and improve quality of care and services delivered to Plan members, and evaluates the effectiveness of the QAPI program. Additional committees and council support the QAPI program and report into the QAPIC:

**Provider Advisory Council** – Solicits input from provider and community stakeholders regarding the structure and implementation of new and existing clinical policies, initiatives and strategies.

**Member Advisory Council** – Provides a forum for member participation and input on Plan programs and policies to promote collaboration, maintain a member focus and enhance the delivery of services to AmeriHealth Caritas Iowa communities.

**Quality of Service Committee** – Monitors performance and quality improvement activities related to the Plan services; reviews, approves and monitors action plans created in response to identified variances.

**Pharmacy and Therapeutics Committee** – Monitors drug utilization patterns, formulary composition, pharmacy benefits management procedures and quality concerns.

**Credentialing Committee** – Reviews practitioner and provider applications, credentials and profiling data (as available) to determine appropriateness for participation in the AmeriHealth Caritas Iowa network.

**Culturally and Linguistically Appropriate Service (CLAS) Workgroup** – Provides direction for Plan activities that are relevant to the 15 national CLAS standards and to NCQA's Multicultural Healthcare Standards to ensure that AmeriHealth Caritas Iowa members are served in a way that is responsive to their cultural and linguistic needs.

## **Practitioner Involvement**

We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Services at 1-844-411-0579 or their Provider Network Account Executive.

## **QAPI Activities**

The QAPI program is designed to monitor and evaluate the quality of care and service provided to members. On-going QAPI activities include:

### **Performance Improvement Projects**

The Plan develops and implements Performance Improvement Projects (PIPs) focusing on areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations.

### **Ensuring Appropriate Utilization of Resources**

The Plan will perform baseline utilization measurements to calculate inpatient admission rates and length of stay, emergency room utilization rates and clinical guideline adherence for preventive health and chronic illness management services to identify those areas that fall outside the expected range to assess for over- or under-utilization.

### **Chronic Care Improvement Programs**

The Plan's Chronic Care Improvement Programs were selected to address the expected high-incidence conditions for which there are evidence-based protocols that have been shown to improve health outcomes.

### **Measuring Member and Practitioner Satisfaction**

The Plan uses the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member satisfaction. The Plan also conducts Practitioner Satisfaction studies annually. Survey results, along with analysis and trends on dissatisfaction and member opt-outs are reported to the QAPIC for review and identification/prioritization of opportunities for improvement.

### **Participant and Practitioner Dissatisfaction**

Dissatisfactions or complaints/grievances from members and providers are investigated, responded to and trended. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.

### **Member Safety Programs**

The QAPI department is responsible for coordinating activities to promote member safety. Initiatives focus on promoting member knowledge about medications, home safety and hospital safety. Members are screened for potential safety issues during the initial assessment.

## Preventive Health and Clinical Guidelines

The QAPIC is responsible for approving all preventive health and clinical guidelines. Guidelines are developed using criteria established by nationally recognized professional organizations and with input from the Plan's Provider Advisory Council. Guidelines are distributed via the Plan's website, with hard copies available upon request.

## Availability and Accessibility Audits

Compliance with the Plan's access and availability standards is monitored annually to ensure sufficient numbers of network providers are available to meet member needs. An assessment is conducted to compare the type, number and location of network practitioners and providers to approved standards. The Quality of Service Committee (QSC) evaluates the report annually. The Plan also conducts an annual assessment of primary care providers' compliance with appointment standards for routine, urgent and sick office visits. Results of the survey are reported to the QSC for review and recommendations.

## Medical Record Requirements

Medical records of network providers are to be maintained in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates access, availability, confidentiality and organization of records at all times. Provider agrees to retain all medical records, whether electronic or paper, for a period of no less than seven (7) years after the last payment was made for the services of the member.

Providers are required by contract to make medical records accessible to the Iowa DHS, the Iowa Department of Public Health (IDPH), the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), and their respective designee's in order to conduct fraud, abuse, waste and/or quality improvement activities.

Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate:

- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient's name or identification number is on each page of record.
- All entries are dated and legible.
- All entries are initialed or signed by the author.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations and illnesses.
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA."
- Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each member.
- Patient's chief complaint or purpose for visit is clearly documented.

- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with the Plan's Preventive Health Guidelines.
- An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).
- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.

## Medical Record Audits

AmeriHealth Caritas Iowa conducts medical record audits to assess the provision and documentation of high quality primary care according to established standards. PCP sites with ten (10) or more linked members undergo a Medical Record Review (MRR) a minimum of once every three (3) years. A PCP practice may include both an individual office and a large group facility site. Ad-hoc reviews of OB-GYN's and specialists may also be conducted, as needed, using the same process.

A minimum of five (5) records are reviewed for each site. Records are selected using a random number methodology among members assigned to the PCP for a minimum of six (6) months.

## Adverse Action Reporting

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas Iowa sends information on reportable events, (as outlined in the NPDB and HIPDB Reporting Manual instructions) to the respective entity and to the State Board of Medical, as appropriate, in the state where AmeriHealth Caritas Iowa is located.

All review outcomes, including actionable information, are incorporated in the provider credentialing file and database.

## Mandatory Reporting Requirements

AmeriHealth Caritas Iowa providers are required to comply with the reporting of specific conditions and diseases in accordance with state regulations and guidelines.

[SPECIFICS OF STATE REPORTING REQUIREMENTS (To be in Appendix)]

## Potential Quality of Care Concerns

Potential quality of care concerns are fully investigated by AmeriHealth Caritas Iowa.

The Medical Director's outcome determination of the quality of care concern may result in a referral to the Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from the Plan's network.

If the concern is referred to the QAPIC, follow-up actions are conducted based on the QAPIC's recommendation(s), which may include sanctioning the practitioner/provider.

If the QAPIC investigation involves a reportable action, the appropriate practitioner/provider's case information will be reported to the National Provider Data Bank (NPDB), Health Integrity and Protection Data Bank (HIPDB) and state regulatory agencies, as required.

The QAPIC reserves the right to impose any of the following actions, based on its discretion:

- Requiring the practitioner/provider to submit of a written description and explanation of the quality of care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. In the event that the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record review audit.
- Requiring that the practitioner/provider conform to a corrective action plan which may include continued monitoring by AmeriHealth Caritas Iowa to ensure that adverse events do not continue. This requirement will be documented in writing. A corrective action plan may also include provisions that the practitioner/provider maintain an acceptable pass/fail score with regard to a particular performance metric.
- Implementing formal sanctions, including termination from the AmeriHealth Caritas Iowa network if the offense is deemed an immediate threat to the well-being of Plan members. AmeriHealth Caritas Iowa reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the corrective actions listed above.

At the conclusion of the investigation of the QAPIC, the practitioner/provider will be notified by letter of the concern of the actions recommended by the QAPIC, including an appropriate time period within which the practitioner/provider must conform to the recommended action.

## Provider Sanctioning Policy

It is the goal of AmeriHealth Caritas Iowa to assure members receive quality health care services. In the event that health care services rendered to a member by a network provider represent a serious deviation from, or repeated non-compliance with, the Plan's quality standards, and/or recognized treatment patterns of the organized medical community, the network provider may be subject to AmeriHealth Caritas Iowa's formal sanctioning process.

Except for any applicable state licensure board reporting requirements, all sanctioning activity is strictly confidential.

## Sentinel Events, Never Events and Critical Incidents

### Reporting Requirements and Methods

AmeriHealth Caritas Iowa monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the

quality of care and service, operations, assets, or the reputation of the Plan. This includes critical incidents, sentinel events and never events, as defined below. The phrase “or risk thereof” includes any process variation for which an occurrence (as in a ‘near miss’) or recurrence would carry a significant chance of a serious adverse outcome.

Important definitions include:

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as “sentinel” because they signal the need for immediate investigation and response. Please note, the terms “sentinel event” and “medical error” as not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events. Examples of a sentinel event include:
  - Maternal death after delivery.
  - Suicide while inpatient.
- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above. Examples of Never Events include:
  - Surgery performed on the wrong patient
  - Surgery on the wrong body part
  - Unintended retention of a foreign object after surgery

See CMS.gov or NQF.org for a complete list

- **Critical Incident** - Retrospective identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function. Examples of Critical incidents include:
  - Physical injury that requires physician treatment or admission to the hospital
  - Results in death
  - Requires emergency mental health treatment for the member
  - Requires intervention by law enforcement
  - Requires report of child abuse
  - Prescription medication error or pattern of errors that results in physical injury, physician’s treatment, hospitalization, death or emergency mental health treatment.

AmeriHealth Caritas Iowa’s goals are to:

- Have a positive impact on improving patient care, treatment and services and prevent unusual occurrences;
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future; and,
- Increase general knowledge about unusual occurrences, their causes and strategies for prevention.

## Reporting Unusual Occurrences

Providers are expected to report unusual occurrences, as described above and including near misses, to the Plan in real time. The Plan recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore, allowance is made for the stabilization of the member prior to reporting. All unusual occurrences must be reported to the Plan within 24 hours of occurrence. Reports may be made to the AmeriHealth Caritas Iowa Risk Manager by calling **1-844-411-0579**.



AmeriHealth Caritas Iowa will not take punitive action or retaliate against any person for reporting an unusual occurrence. The practitioners involved will be offered the opportunity to present factors leading to the unusual occurrence and to respond to any questions arising from the review of the unusual occurrence.

Once an AmeriHealth Caritas Iowa staff member identifies or is notified of an unusual occurrence, as defined above, the following procedures will take place to investigate and address the occurrence:

1. The Director, Quality and Risk Management is notified of the event via an incident report, telephone, email or personal visit as soon as reasonably possible after identification of the occurrence.
2. The Director, Quality and Risk Management will collaborate with the Chief Medical Officer and investigate as appropriate. Certain occurrences may require review of medical records to assist in the investigation.
3. The Quality department leads the investigation; analysis and reporting of all identified unusual occurrences.
4. All unusual occurrences require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance. A multidisciplinary team led by the Chief Medical Officer will perform all root cause analysis.
5. As appropriate, issues are identified for correction and corrective action plans are developed to prevent reoccurrence of the event. The corrective action plan will identify strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan will address responsibility for implementation, oversight, time lines and strategies for measuring the effectiveness of the actions.
6. Confirmed critical incidents and sentinel events will be reported to the Iowa DHS within 24 hours of occurrence or as soon as a determination is made that the occurrence is a critical incident or sentinel event. Additionally, the Plan will report all critical incidents and sentinel events, as well as actions taken, to the Iowa DHS on a quarterly basis.
7. As appropriate, other agencies will also be notified of confirmed critical incidents and sentinel events.
8. As appropriate, information from the investigation of unusual occurrences will be provided to the Credentialing Committee to support the re-credentialing process.

## Reporting Provider Preventable Conditions

Please refer to the “Claims Submission Protocols and Standards” section of this *Provider Manual* for more information regarding AmeriHealth Caritas Iowa’s reimbursement policy on provider preventable conditions and how to report such conditions via the claims process.

## Credentialing Program

AmeriHealth Caritas Iowa’s Quality Assessment and Performance Improvement Program (QAPI) provides oversight of the Credentialing Program. The activities described below are additional functions of the Credentialing Program. For more information on the credentialing and re-credentialing processes, please refer to the “Provider and Network Information” section of this *Provider Manual*.

## Formal Sanctioning Process

Following a determination to initiate the formal sanctioning process, AmeriHealth Caritas Iowa will send the practitioner/provider written notification of the following by certified mail or via another means providing for evidence of receipt. The notice will include:

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with AmeriHealth Caritas Iowa on the proposed action.
- Reminder that the practitioner/provider has 30 days following receipt of notification within which to submit a written request for a hearing. Otherwise, the right to a hearing will be forfeited. The practitioner/provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action he/she wishes to contest.
- Notification that the practitioner/provider may waive his/her right to a hearing and that the right will be considered waived if no written request for a hearing is submitted.

## Notice of Hearing

If the provider requests a hearing in a timely manner the provider will be notified of the following in writing:

- The place, date and time of the hearing, which will not be less than 30 days after the date of the notice.
- That the provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the AmeriHealth Caritas Iowa Medical Director and/or upon advice of the AmeriHealth Caritas Legal Affairs department.
- A list of witnesses (if any) expected to testify at the hearing on behalf of AmeriHealth Caritas Iowa.

## Conduct of the Hearing and Notice

The hearing will be held before a panel of individuals appointed by AmeriHealth Caritas Iowa (the Hearing Panel), as follows:

- Individuals on the Hearing Panel will not be in direct economic competition with the practitioner/provider involved, nor will they have participated in the initial decision to propose sanctions.
- The Hearing Panel will be composed of physician members of AmeriHealth Caritas Iowa's quality-related committees, AmeriHealth Caritas Iowa's Medical Director and/or designee, and other physicians and administrative persons affiliated with AmeriHealth Caritas Iowa as deemed appropriate by the Plan's Medical Director, such as legal counsel.
- AmeriHealth Caritas Iowa's Medical Director or his/her designee serves as the Hearing Officer.
- The right to the hearing will be forfeited if the practitioner/provider fails, without good cause, to appear.

## Provider Hearing Rights

The provider has the right to:

- Representation by an attorney or other person of the provider's choice;
- Have a record made of the proceedings (copies of which may be obtained by the provider upon payment of reasonable charges associated with the preparation);
- Call, examine and cross-examine witnesses;
- Present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law;
- Submit a written statement at the close of the hearing;
- Receive the written recommendation(s) of the Hearing Panel within 15 working days of completion of the hearing, including statement of the basis for the Hearing Panel's recommendation(s), which will be provided by certified mail or via another means providing for evidence of receipt; and,



- Receive AmeriHealth Caritas Iowa's written decision within 60 days of completion of the hearing, including the basis for AmeriHealth Caritas Iowa's decision(s), which will be provided by certified mail or via another means providing for evidence of receipt.

### **Appeal of AmeriHealth Caritas Iowa Decision**

The provider may request an appeal after the final decision of AmeriHealth Caritas Iowa.

The practitioner/provider must submit a written appeal by certified mail or via another means providing evidence of receipt, within 30 days of the receipt of the Plan's decision; otherwise the right to appeal is forfeited.

Written appeal will be reviewed and a decision rendered by the Plan's QAPIC within 45 days of receipt of the notice of the appeal.

### **Summary Actions Permitted**

The following summary actions can be taken, without the need to conduct a hearing, by the Regional President or Market President of AmeriHealth Caritas Iowa or by the Plan's Medical Director:

- Suspension or restriction of the Plan's participation status for up to 14 days, pending an investigation to determine the need for formal sanctioning process; or,
- Immediate suspension or revocation, in whole or in part, of panel membership or participating practitioner/provider status, subject to subsequent notice and hearing, when it is determined that failure to take such action may result in immediate danger to the health and/or safety of any individual. A hearing will be held within 30 days of the summary action to review the basis for continuation or termination of this action.

## **Section VIII**

# **Cultural Competency Program and Requirements**

## VIII. Cultural Competency Program and Requirements

### Introduction

Embedded in all AmeriHealth Caritas Iowa efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our provider community, by leveraging ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network.

AmeriHealth Caritas Iowa routinely examines the access to care standards for both the general population and the population who speaks a threshold language. A threshold language is a language spoken by at least five percent or 1,000 members of AmeriHealth Caritas Iowa's member population. In addition, every edition of the provider newsletter includes a pertinent article on addressing cultural or language issues.

Our Cultural Competency Program, led by a cross-departmental workgroup, has been built upon the following 15 national standards for Culturally and Linguistically Appropriate Services (CLAS) as set forth by the U.S. Department of Health and Human Services:

### Principal Standard

1. Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

### Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

### Communication of Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

### Engagement, Continuous Improvement and Accountability

9. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance-resolution process that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

Providers may request more information on the Cultural Competency Program by contacting Provider Services at **1-844-411-0579**.

## Cultural and Linguistic Requirements

Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Section 4302 of the Affordable Care Act supports the self-reported collection of race, ethnicity, sex, primary language and disability status according to the Office of Management and Budget (OMB categories). This provision allows ACI to comply with federal and national provisions established to reduce health disparities and deliver culturally competent care.

As a provider of health care services who receives federal financial payment through the Medicaid program, you are responsible to make arrangements for language services for members, upon request, who are either Limited English Proficient (LEP) or Low Literacy Proficient (LLP) to facilitate the provision of health care services to such members.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/health care provider relationship. The key to ensuring equal access to benefits and services for LEP, LLP and sensory impaired members is to ensure that you, our Network Provider, can effectively communicate with these members. Plan providers are obligated to offer translation services to LEP and LLP members upon request and to make reasonable efforts to accommodate members with other sensory impairments.

Providers should discourage members from using family or friends as oral translators. Members should be advised that translation services from AmeriHealth Caritas Iowa are available. Providers are required to:

- Offer written and verbal language access at no cost to Plan members with limited- English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent interpreters, as necessary.
- Offer members verbal or written notice (in their preferred language or format) about their right to receive free language services assistance.

- Post and offer easy-to-read member signage and materials in the languages of the common cultural groups in the Provider's service area. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.
- Discourage members from using family or friends as oral translators.

Advise members that language services are available through AmeriHealth Caritas Iowa, if the Provider is not able to obtain necessary language services for a member.

**Note:** The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation services and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

When a member uses the Plan's interpretation services, the provider must sign, date and complete documentation in the medical record in a timely manner.

AmeriHealth Caritas Iowa contracts with a competent telephonic interpreter service provider. We have an arrangement to make our corporate rate available to participating plan providers. If you need more information on using this telephonic interpreter service, please contact Provider Services at 1-844-411-0579.

Health care providers who are unable to arrange for interpretation services for an LEP, LLP or sensory impaired member should contact Member Services at 1-855-332-2440 and a representative will help locate a professional interpreter to communicate in the member's primary language.

Additionally under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan Providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all members in a manner compatible with the member's cultural health beliefs and practices of preferred language/format;
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area;
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services;
- Establish written policies to provide interpretive services for plan members upon request; and,
- Routinely document preferred language or format, such as Braille, audio, or large type, in all member medical records.

## Enhancing Cultural Competency in Health Care Settings

AmeriHealth Caritas Iowa encourages providers and their staff to report their race and ethnicity and the languages they speak. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare, or CAQH.

Provider and member information is analyzed to identify opportunities for improvement so AmeriHealth Caritas Iowa can provide the best possible service to its providers and members.

The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.

### Additional resources

The following additional resources are available:

- HHS Health Resources and Services Administration: Culture, Language Health Literacy

- National Institutes of Health: Clear Communication / Cultural Competency
- Health Literacy Innovations™
- The Health Literacy & Plain Language Resource Guide

## Cultural Sensitivity Training

In an effort to deliver culturally sensitive and appropriate care to members have limited English proficiency, represent diverse cultural and ethnic backgrounds, special health needs, who are poor, homeless, and or from a minority population group, AmeriHealth Caritas Iowa requires providers to complete an annual cultural competency training that will address:

- Delivering services and care that honors members' beliefs
- Understanding and providing services in a manner that is sensitive to cultural diversity
- Fostering attitudes and interpersonal communication styles that respect diverse cultural backgrounds
- Addressing health disparities, the social determinants of health, and health literacy

Providers are also encouraged to complete the free e-learning cultural competency training offered by HHS Office of Minority Health titled, "A Physician's Practical Guide to Culturally Competent Care". This training offers up to 6 CEU's can be accessed at: <https://cccm.thinkculturalhealth.hhs.gov/>

## Terms and definitions

Providers should be aware of the following terms and their definitions:

**Cultural competence** The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. "Competence" implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities. Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location.

**Individuals with Limited English Proficiency (LEP).** Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

**Low literacy proficiency:** In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve his or her goals and develop his or her knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.

**Sensory impaired:** a person who is deaf or visually impaired

## **Section IX**

# **Claims Submission Protocols and Standards**

# IX. Claims Submission Protocols and Standards

## CLAIMS SUBMISSION

All claims for services rendered by in-network providers must be submitted to AmeriHealth Caritas Iowa within 90 days from the date of service (or the date of discharge for inpatient admissions). Claims submitted by practitioners must be billed on the CMS-1500 or UB-04 or via the electronic equivalent (EDI) of these standard forms. The following mandatory information is required on all claims:

- Member's (patient's) name
- Member's Medicaid ID number
- Member's date of birth and address
- Other insurance information: company name, address, policy and/or group number
- Amounts paid by other insurance (with copies of matching EOBs)
- Information advising if member's condition is related to employment, auto accident or liability suit
- Date(s) of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-10-CM (or successor) diagnosis codes, coded to the correct 4<sup>th</sup> or 5<sup>th</sup> digit
- Authorization number, as applicable
- Name of referring physician, if appropriate
- HCPCS procedures, services or supplies codes
- CPT procedure codes with appropriate modifiers
- CMS place of service code
- Charges (per line and total)
- Days and units
- Physician/supplier Federal Tax Identification Number or Social Security Number
- National Practitioner Identifier (NPI) and Taxonomy
- Physician/supplier billing name, address, zip code, and telephone number
- Name and address of the facility where services were rendered
- NDC's required for physician administered injectables that are eligible for rebate
- Invoice date
- Signature

Note: AmeriHealth Caritas Iowa also encourages providers to submit claims using:

- Plan-assigned individual practitioner ID numbers
- Plan-assigned member ID numbers

Out-of-network providers are required to submit claims within twelve (12) months from the date of service.

## General Procedures for Claim Submission

AmeriHealth Caritas Iowa is required by state and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

When required data elements are missing or invalid, claims will be **rejected** by the Plan for correction and re-submission. Claims for billable services provided to AmeriHealth Caritas Iowa members must be submitted by the provider who performed the services.



Claims filed with AmeriHealth Caritas Iowa are subject to the following procedures:

- Verification that all required fields are completed and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an out-of-network provider has received authorization to provide services to the eligible member.
- Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas Iowa.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that the Plan is the “payer of last resort” on all claims submitted to AmeriHealth Caritas Iowa.

AmeriHealth Caritas Iowa accepts paper and electronic claims. Plan providers and practitioners are encouraged to submit claims electronically for faster turn-around.

For more detailed billing information and line-by-line instructions, please refer to the *Claims and Billing Manual*, available in the provider area of our website at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com).

## Electronic Claims Submission (EDI)

AmeriHealth Caritas Iowa encourages all providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or Emdeon’s Provider Support Line at **1-877-363-3666** for more information.

There are many different products that may be used to bill electronically. As long as you have the capability to send EDI claims to Emdeon, whether through direct submission or through another clearinghouse/vendor, you may submit claims electronically.

Providers interested in sending claims electronically may contact the EDI Technical Support at **1-844-341-7644** at to arrange transmission and for assistance in beginning electronic submissions. When ready to proceed:

- Contact your EDI software vendor or Emdeon at **1-877-363-3666** to inform them you wish to initiate electronic claim submissions to AmeriHealth Caritas Iowa.
- Be prepared to inform the vendor of the Plan’s electronic payer identification number.

AmeriHealth Caritas Iowa’s EDI Payer ID#: **77075**

## Paper Claim Mailing Instructions

Please submit paper claims to the address below:

AmeriHealth Caritas Iowa  
Attn: Claims Processing Department  
P.O. Box 7113  
London, KY 40742

## Claim Filing Deadlines

All original paper and electronic claims must be submitted to AmeriHealth Caritas Iowa within 90 calendar days from the date services were rendered (or the date of discharge for inpatient admissions). This applies to capitated and fee-for-service claims. Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim

being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.

**Rejected claims** are defined as claims with missing or invalid data elements, such as the provider tax identification number or member ID number, that are returned to the provider or EDI source without registration in the claim processing system. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim. Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data within 90 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

**Denied claims** are registered in the claim processing system but do not meet requirements for payment under AmeriHealth Caritas Iowa guidelines. They should be re-submitted as a corrected claim. Claims originally denied must be re-submitted as a corrected claim within 365 days of the original date of service.

**Claims with Explanation of Benefits (EOBs)** from primary insurers, including Medicare, must be submitted within 60 days of the date on the primary insurer's EOB.

## IMPORTANT BILLING REMINDERS

### Encounter Reporting

#### Visit Reporting

CMS defines an encounter as "an interaction between an individual and the health care system." Encounters occur whenever an AmeriHealth Caritas Iowa member is seen in a provider's office or facility, whether the visit is for preventive health care services or for treatment due to illness or injury. An encounter is any health care service provided to a Plan member. Encounters must result in the creation and submission of an encounter record (CMS-1500 or UB-04 form or electronic submission) to AmeriHealth Caritas Iowa. The information provided on these records represents the encounter data the Plan reports to the state, according to mandatory reporting requirements.

#### Completion of Encounter Data

PCPs must complete and submit a CMS-1500 or UB-04 form or file an electronic claim every time an AmeriHealth Caritas Iowa member receives services from the provider. Completion of the CMS-1500 or UB-04 form or electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services.
- It allows the Plan to gather statistical information regarding the medical services provided to members, which better support our statutory reporting requirements.
- It allows the Plan to identify the severity of illnesses of our members.

AmeriHealth Caritas Iowa accepts encounter submissions via paper or electronically (EDI). For more information on electronic claim submission and how to become an electronic biller, please contact the EDI Technical Support Hotline at **1-844-341-7644** or refer to the billing information available on our Plan website at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com).

In order to support timely statutory reporting requirements, PCPs must submit encounters within thirty (30) days of the visit.

AmeriHealth Caritas Iowa monitors encounter data submissions for accuracy, timeliness and completeness through claims processing edits and through network provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely and incomplete information. Network

providers will be notified of the rejection via a remittance advice and are expected to re-submit corrected information to the Plan. Network providers may also be subject to sanctioning by the Plan for failure to submit accurate encounter data in a timely manner.

## Claims Inquiry

If a provider does not receive payment for a claim within 45 days or has concerns regarding any claim issue, claims status information is available by:

- Visiting the NaviNet provider website, our secure provider portal. Log on to [www.navinet.navimedix.com](http://www.navinet.navimedix.com) for web-based solutions for electronic transactions and information..
- Calling Provider Services at **1-844-411-0579** and following the prompts.
- Calling your Account Executive for assistance.

## Balance Billing Members

Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas Iowa to participating Plan providers must be accepted as payment in full for services rendered. Members may not be balanced billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims dispute processes to resolve any outstanding claims payment issues.

## Requests for Adjustments

Requests for adjustments may be submitted electronically (via EDI), on paper or by telephone.

By Telephone:

Provider Claim Services

**1-844-411-0579**

(Select the prompts for the correct department and then select the prompt for claim issues.)

On Paper:

If you prefer to write, please be sure to each claim submitted “corrected” or “re-submission” and address the letter to:

AmeriHealth Caritas Iowa  
Attn: Claims Processing Department  
P. O. Box 7113  
London, KY 40742

## Claim Disputes

If a claim or a portion of a claim is denied for any reason or underpaid, the provider may dispute the claim within 60 days from the date of the denial or payment. A telephone inquiry regarding payment or denial of a claim does not constitute dispute of the claim. Claim disputes must be submitted in writing, along with supporting documentation, to:

AmeriHealth Caritas Iowa  
Attn: Claim Disputes  
P. O. Box 7122  
London, KY 40742

## Refunds for Improper Payment or Overpayment of Claims

If a Plan provider identifies improper payment or overpayment of claims from AmeriHealth Caritas Iowa the improperly paid or overpaid funds must be returned to the Plan. Providers are required to return the identified funds to the Plan by submitting a refund check directly to the claims processing department:

AmeriHealth Caritas Iowa  
Attn: Provider Refunds  
P. O. Box 7113  
London, KY 40742

Note: Please include the member's name and ID, date of service and claim ID.

## Third Party Liability/Subrogation

### *Third Party Liability and Coordination of Benefits*

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than AmeriHealth Caritas Iowa. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as AmeriHealth Caritas Iowa, are always the payer of last resort. This means that all other insurance carriers (the "Primary Insurers") must consider the Health Care Provider's charges before a Claim is submitted to AmeriHealth Caritas Iowa. Therefore, before billing AmeriHealth Caritas Iowa when there is a Primary Insurer, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill AmeriHealth Caritas Iowa for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. **Claims with Explanation of Benefits (EOBs)** from primary insurers, including Medicare, must be submitted within 60 days of the date on the primary insurer's EOB

In the event of an accidental injury (personal or automobile) where a third party payer is deemed to have liability and makes payment for services that have been considered and paid under the AmeriHealth Caritas Iowa contract, the Plan will be entitled to recover any funds up to the amount owed by the third party payer.

## ADDITIONAL INFORMATION FOR ELECTRONIC BILLING

### Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass Emdeon HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted with all necessary and valid data elements within the required filing deadline of 90 days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Emdeon or your EDI software vendor in order to identify and re-submit these claims accurately.

### Monitoring Reports for Electronic Claims

Emdeon will produce an Acceptance Report\* and a R059 Plan Claim Status Report\*\* for its trading partner whether that is the EDI vendor or provider. Providers using Emdeon or other clearinghouses and vendors are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments. In order to verify satisfactory receipt and acceptance of submitted records, please review both the Emdeon Acceptance Report and the R059 Plan Claim Status Report.

\*Acceptance Report verifies acceptance of each claim at Emdeon.

\*\*R059 Plan Claim Status Report is a list of claims that passed Emdeon's validation edits. However, when the claims were submitted to the Plan, they encountered provider or member eligibility edits.

## Plan Specific Electronic Edit Requirements

AmeriHealth Caritas Iowa currently has two specific edits for professional and institutional claims sent electronically.

- **837P – 005010X098A1** – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
- **837I – 005010X096A1** – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Statement date must be not be earlier than the date of service.

Plan-assigned individual practitioner ID number is strongly encouraged.

## Electronic Billing Exclusions

Certain claims are excluded from electronic billing and must be submitted by paper. These exclusions fall into two groups:

Excluded Claim Categories
Claim records requiring supportive documentation (but not including secondary claims with COB information).
Claim records for medical, administrative or claim appeals.
Excluded Provider Categories
Providers not transmitting through Emdeon or providers sending to vendors not transmitting through Emdeon.
Pharmacists (through Emdeon).

(These exclusions apply to inpatient and outpatient claim types.)

## Common Rejections

Invalid Electronic Claim Records – <i>Common Rejections from Emdeon</i>
Claims with missing or invalid batch level records.
Claim records with missing or invalid required fields.
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-9, etc.).
Claims without member ID numbers (including Medicaid and/or Plan ID numbers).
Invalid Electronic Claim Records – <i>Common Rejections from AmeriHealth Caritas Iowa (EDI Edits within the Claim System)</i>
Claims received with invalid provider numbers (including NPI and Taxonomy, Medicaid ID and/or Plan ID, as applicable).
Claims received with invalid member ID numbers (including Medicaid and/or Plan ID numbers).
Claims received with invalid member date of birth.

## Re-submitted Corrected Claims

Providers using electronic data interchange (EDI) can submit “institutional” and “professional” corrected claims\* electronically to AmeriHealth Caritas Iowa.

\*A “corrected claim” is defined as a re-submission of a claim with a specific change you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim.

Your EDI clearinghouse or vendor needs to remember the following:

- ✓ Use “6” for adjustment of prior claims or “7” for replacement of a prior claim utilizing bill type or frequency type in loop 2300, CLM05-03 (837P or 837I).
- ✓ Include the original claim number in segment REF01=F8 and REF02=the original claim number; do not use dashes or spaces.
- ✓ Also, when submitting a corrected claim:
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied).
- ✓ **Do** include the Plan’s claim number in order to submit your claim with the 6 or 7.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront).
- ✓ **Do not** submit corrected claims electronically and via paper at the same time.
  - a. For more information, please contact the Plan’s EDI Technical Support Hotline at 1-844-412-7644 or [edi.aciowa@amerihealthcaritas.com](mailto:edi.aciowa@amerihealthcaritas.com)

## Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically...	Contact Emdeon: <b>1-877-363-3666</b>
If you have general EDI questions ...	Contact EDI Technical Support: <b>1-844-341-7644</b> or <a href="mailto:edi.aciowa@amerihealthcaritas.com">edi.aciowa@amerihealthcaritas.com</a>
If you have questions about specific claims transmissions or Acceptance and R059 - Claim Status reports...	Contact your EDI software vendor or call the Emdeon Provider Support Line: <b>1-800-845-6592</b>
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)...	Contact Provider Claim Services: <b>1-844-411-0579</b>
If you have questions about claims that are reported on the remittance advice...	Contact Provider Claim Services: <b>1-844-411-0579</b>
If you need to know your provider NPI number...	Contact Provider Services: <b>1-844-411-0579</b>
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information OR For questions about changing or verifying provider information...	Please Contact Provider Services: By Fax: <b>1-844-412-7886</b> By Telephone: <b>1-844-411-0579</b>
If you would like information on the 835 remittance advice...	Contact your EDI vendor or call Emdeon: <b>877-363-3666</b>
Check the status of your claim...	Review the status of your submitted claims on NaviNet at <a href="http://www.navinet.navimedix.com">www.navinet.navimedix.com</a> .
Sign-up for the Provider Portal...	Go to <a href="http://www.navinet.net">www.navinet.net</a> or contact NaviNet Customer Service: <b>888-482-8057</b>
Sign-up for Electronic Funds Transfer...	Contact Emdeon: <b>877-363-3666</b>

## PROVIDER PREVENTABLE CONDITIONS

AmeriHealth Caritas Iowa will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions.

The category of Health Care Acquired Conditions (HCAC) applies to Medicaid inpatient hospital settings only. Under this category, the Plan does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery
- Air Embolism



- Blood Incompatibility
- Catheter Associated Urinary Tract Infection
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter Associated Infection
- Mediastinitis After Coronary Artery Bypass Graft (CABG)
- Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes)
- Manifestations of Poor Glycemic Control
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures Except for Pediatric and Obstetric Populations

The category of Other Provider-Preventable Conditions (OPPC) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs. Under this category, the Plan will not reimburse providers for any of the following never events in any inpatient or outpatient setting:

- Surgery Performed on the Wrong Body Part
- Surgery Performed on the Wrong Patient
- Wrong Surgical Procedure Performed on a Patient

## Mandatory Reporting of Provider Preventable Conditions

In addition to broadening the definition of PPCs, the ACA requires payers to make pre-payment adjustments. **Therefore, a PPC must be reported by the provider at the time a claim is submitted.** Note that this requirement applies even if the provider does not intend to submit a claim for reimbursement for the service(s) rendered.

Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a “Present on Admission” indicator.
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; the Plan will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

## For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the E diagnosis codes, such as E876.5, E876.6 or E876.7 in field 21 [and/or] field 24E.

## For Facility Claims (UB-04 or 837I)

When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 (or successor) diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q. Examples of ICD-10 and “E” diagnosis codes include:

- Wrong surgery on correct patient E876.5;
- Surgery on the wrong patient, E876.6;
- Surgery on wrong site E876.7

- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 “Expired”.

## Inpatient Claims

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired.

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted via the paper claims process with the member’s medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC from the DRG. Facilities do not need to submit copies of medical records for PPCs associated with this payment type.

## Indicating Present on Admission (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the “Present on Admission” (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG-based facilities may submit POA via 837I in loop 2300; segment K3, data element K301.

Valid POA Indicators Include:

- “Y” = Yes = present at the time of inpatient admission
- “N” = No = not present at the time of inpatient admission
- “U” = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission
- “W” = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not “null” = Exempt from POA reporting

## SURGICAL REIMBURSEMENT POLICIES

### Pre-Operative Test Requirements

It is the surgeon’s responsibility to provide information to the member on the hospital’s requirements for pre-operative physical examination, laboratory and radiology tests. Lab specimens may be drawn by the surgeon or PCP and sent to the appropriate participating lab for work-up.

### Multiple Procedures

Multiple surgical or invasive procedures are paid at a reduced rate. The primary procedure is paid at one hundred percent (100%) of the allowable charge. Subsequent procedures will be paid at fifty (50%) of the allowable charge or per provision of the individual practitioner’s contract.

### Incidental Surgery

Incidental procedures are not reimbursed as separate charges when they are performed in conjunction with other surgical procedures. The following are a few examples of incidental procedures:

- Procedures to create surgical entry
- Exploratory laparotomy
- Incidental appendectomy

## Assistant Surgeons

AmeriHealth Caritas Iowa follows Medicare guidelines for reimbursement of assistant surgeon services. According to the Medicare Fee Schedule, the following assistant surgeon services are not reimbursed when billed with the assistant surgeon modifier (80):

- Procedures where assistant surgeons are not allowed.
- Procedures that do not require an assistant surgeon or are not surgical in nature.
- Global obstetrical deliveries.

Additionally, the assistant surgeon component will be denied on claims where the primary surgeon and assist surgeon are listed as the same provider. Services provided by a second assistant surgeon are also not reimbursable for most surgical procedures.

## Global Surgical Reimbursement

Pre-and post-operative visits are considered to be part of the surgical fee. Visits do not fall within the Medicare surgical global guidelines; therefore, payment for visits will be denied.

## **Section X Behavioral Health Care**

## X. Behavioral Health Care

### Introduction

Behavioral Health Services are a critical part of the overall package of care provided to Members of AmeriHealth Caritas of Iowa. Account Executives assigned to work with our Behavioral Health providers will have a behavioral health background and have experience with the behavioral health system in Iowa. Please note that, in general, the responsibilities, expectations and processes outlined in this *Provider Manual* pertain to all providers, including behavioral health providers, unless otherwise indicated in this section or specified via subsequent communications. .

### Credentialing of Behavioral Health Providers

AmeriHealth Caritas Iowa will assure access to the full scope of care and service resources within established state standards of access and choice for all Plan members. All behavioral health network providers are credentialed and re-credentialed to provide clinical care and services.

The following types of individual providers, facilities and provider organizations that provide only behavioral health and / or HCBS services fall under the authority of the behavioral health credentialing/re-credentialing process:

- Independently Practicing Licensed Physicians (Psychiatrist / Addictive Medicine)
- Independently practicing Licensed Psychologists
- Independently practicing Licensed Behavioral Health Clinicians (LPC, LMFT, LCISW, LMFT)
- Hospital/Inpatient Facilities
- Community Mental health Centers
- Behavioral Health Intervention Services
- - Case Management Provider
- Assertive Community Treatment (ACT) Program
- Habilitation Services
- Residential Care Facility
- Nursing Facility - Mentally Ill
- Iowa Medicaid Provider Type 99 – Home and Community Based Service (HCBS)

Other provider types that offer both medical and behavioral health services are covered in the medical credentialing section above:

- FQHC, Iowa Medicaid provider type 49
- Rural health clinic, Iowa Medicaid provider type 13
- Home health agency, Iowa Medicaid provider type 9
- Screening center, Iowa Medicaid provider type 30
- Health home, Iowa Medicaid provider type 71
- Community based ICF/ID, Iowa Medicaid provider type 27

AmeriHealth Caritas Iowa strives to offer a provider network that provides the highest level of quality, as well as adequate choices and convenience to members.

### Behavioral Health Practitioner / Provider Credentialing Rights

#### Right to Review Information Submitted

Behavioral health providers have the right to review information submitted to support the credentialing application process with the exception of peer references and National Practitioner Data Bank (NPDB)

reports. Currently peer references are not required as part of the credentialing process. In addition, behavioral health providers have the right to be notified of information received by the plan that is substantially different than was reported by the provider. Practitioners will be sent a letter notifying them of the information that varies substantially from what was received.

### **Right to Correct Erroneous Information**

Behavioral health providers have the right to correct erroneous information submitted in support of their credentialing application. Corrections must be submitted in writing to the Credentialing Department within ten (10) business days of notification of the erroneous information. Corrections or information received will be reviewed and documented in the practitioner's file.

### **Right to be Informed of Application Status**

Behavioral health providers may request information about the status of the application they submitted at any time during the credentialing process. Such requests must be made to the Credentialing Coordinator, who will provide information about the status of the application, including whether or not it was received, whether or not it is complete, and/or whether or not it is scheduled to be presented to the Credentialing Committee, etc.

## **Behavioral Health Provider Application Process**

### **Individual Practitioner Application**

The application process for individual behavioral health practitioners requires submission of a completed application. The application must include evidence, such as copies of diplomas, licenses, insurance riders, documentation of privileges, etc. Applications may be obtained by visiting the AmeriHealth Caritas Iowa website at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com) or by contacting your account executive

If you are a participant with Council for Affordable Quality Healthcare (CAQH), you must approve AmeriHealth Caritas Iowa to pull the application from CAQH. Through CAQH, each practitioner determines what entity is eligible to receive his or her credentialing information. Providers who have elected "universal" status need not do anything in order for AmeriHealth Caritas Iowa to receive their information. If you do not have broad distribution permissions, please select AmeriHealth Caritas Family of Companies or AmeriHealth Caritas Iowa for us to receive your application. Practitioners that do not participate with CAQH can download a copy of the Iowa Universal Application from the Iowa website. Completed applications may be returned to AmeriHealth Caritas Iowa for review and primary source verification. Following the primary source verification process, the Credentialing Committee or Medical Director will make a determination regarding network participation.

### **Professional Provider Organization and Facility Application Process**

Facility and professional provider organizations must complete a facility application. The following types of organizations are considered facilities:

- Hospitals
- Free Standing Psychiatric Facilities
- Chemical Dependency Treatment Centers
- Partial Hospitalization Programs
- Accredited Outpatient Facilities
- Department of Mental Health Core Services Agencies
- Other Facility-Based Services/Programs

Please download your application at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com), complete and fax to: **215-863-6369** or contact your account executive for assistance.

## Credentialing Site Visit

Following receipt and review of the facility application, an Account Executive will schedule a site visit if the facility is not accredited by JCAHO, CARF or COA or if the provider is anticipated to be a high volume provider. The credentialing site visit includes a tour of all program areas of the organization, interview with senior administrative, clinical and direct care staff and review of additional written material and documentation. The on-site documentation review may include:

- Policy and procedure manuals
- Licensing documentation
- Accreditation documentation
- Program, treatment or other service protocols
- Program schedules
- Quality Improvement/Assurance Plan and reports
- Discussion about medical record documentation practices, review of a blind treatment record and review of documentation policy and procedure

A score of 85% on the site visit is required. The Account Executive will assist the provider to the extent practical and appropriate relative to improvement. The Account Executive will provide a report with recommendations for improvement to the provider and will re-visit the site within six (6) months to assess progress. Assistance will be documented in the provider's file and will include the dates and the types of assistance provided. This will continue until the provider meets the site visit standards or declines further participation in the process.

The application and site visit report are reviewed by the Credentialing Committee for an approval/disapproval determination regarding the organization's/facility's network participation.

## Credentialing Committee Decision

AmeriHealth Caritas Iowa does not make credentialing/re-credentialing decisions based on the applicants' race, ethnic/national identity, gender, age, sexual orientation, the types of procedures in which the practitioner specializes or the patients for which the practitioner provides care. In developing its network, AmeriHealth Caritas Iowa strives to meet the cultural and special needs of members.

Applicants are notified of their initial credentialing approval within 60 days of the Credentialing Committee's or Medical Director's recommendation. Should the Credentialing Committee or Medical Director elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

## Re-credentialing

Re-credentialing involves periodic review and re-verification of clinical credentials of network practitioners and providers. The re-credentialing process occurs at least every three years. The re-credentialing process includes an up-to-date re-examination of all the submitted materials and a review of the following:

- Member complaints and grievances
- Results of quality indicators monitoring and evaluating activities
- Re-verification of licensure standing
- Re-verification of hospital privileges
- Accreditation of facilities
- Sanction history

## Adding a New Site or Service



When a high volume provider relocates or opens a new site, AmeriHealth Caritas Iowa must evaluate the new site. Practitioners and providers are contractually bound to report changes that affect referrals. Non-accredited, high volume or potential high volume providers require a site visit prior to seeing members so please plan accordingly. While the definition may vary from time to time, currently, a high volume provider is one who sees 200 or more unique members in a 12 month period.

Facility Providers who are adding a new service or site must complete Part II of the initial credentialing application and submit it with required attachments to the attention of their designated Account Executive. The Account Executive will notify you if a site visit is necessary.

### **Address Changes**

As a reminder, providers are contractually bound to report changes that affect referrals, such as the relocation of an office site. If your office is considered high volume, relocation of your office site will require a site visit from AmeriHealth Caritas Iowa.

## **Contracting and Rate Notices**

### **Contracts**

AmeriHealth Caritas Iowa uses an Ancillary Provider Agreement that is approved by all the appropriate local authorities. Provider Agreements automatically renew each year. An amendment to the agreement will be generated only if new services are added due to a change in the state Medicaid program. Rate Notices are used to document rate or per diem changes to existing services.

### **Rate Notices and Fee Schedules**

The fee schedule is reviewed regularly and rates are adjusted as necessary. As a network provider, you will occasionally receive a “Rate Notice” which is an official amendment to the Provider Agreement. Providers will receive 30 days’ notice of rate changes. Providers who do not accept the terms of the Rate Notice may terminate the agreement upon 30 days’ written notice.

Please review EOB’s closely to assure that you begin receiving the new rates for services delivered on or after the date indicated upon notice of an updated fee schedule. You are responsible to monitor payment received from the Plan. In the event of a discrepancy, please contact your Account Executive immediately. AmeriHealth Caritas Iowa strongly suggests provider’s bill the usual and customary charges rather than the rate indicated on the Rate Notice. In the event of a system or data entry error, this practice will help you avoid the need to resubmit corrected claims when the issue is resolved.

## **Behavioral Health Covered Services**

See Section III “Provision of Services” for Behavioral Health covered Services.

### **Access to Behavioral Health Care**

AmeriHealth Caritas Iowa providers must meet standard guidelines as outlined in this publication to help ensure that Plan members have timely access to behavioral health care.

The Plan endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. AmeriHealth Caritas Iowa establishes mechanisms for measuring compliance with existing standards and identifying opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for members should comply with the access standards defined below.

The standards below apply to behavioral health care services and behavioral health providers; please refer to the “Provider and Network Information” section of this *Provider Manual* for the standards that apply to health care services and medical providers.

Access to Behavioral Health Care	
Emergency Psychiatric or Mental Health Care <i>(An active crisis where the member or others are at risk, or where there is an expected risk in the next 24 hours.)</i>	Within fifteen (15) minutes of presentation at a service delivery site
Urgent Psychiatric or Mental Health Care	Within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with the provider or health plan.
Mobile Crisis	Members in need of mobile crisis services shall receive services within one (1) hour of presentation of request.
Inpatient, residential, intensive outpatient and partial hospitalization	<i>Distance:</i> Sixty (60) miles from the personal residence of members in urban areas and ninety (90) minutes from the personal residence of members in rural areas using GeoAccess standards for rural and urban travel time.
Outpatient services:	<i>Distance:</i> Distance: Thirty (30) miles or (30) minutes from the personal residence of members except where community standards and documentation shall apply.
Behavioral Health Telephone Crisis Triage	Within 15 Minutes Over the Telephone <i>Must be Available on a 24-Hour Basis, Seven Days a Week.</i>
Persistent symptoms	Members with persistent symptoms shall be seen by and appropriate provider within forty-eight (48) hours of reporting symptoms
Psychiatric Intervention or Face-to-Face Assessment	Within 90 Minutes of Completion of Telephone Assessment, As Needed <i>Must be Available on a 24-Hour Basis, Seven Days a Week.</i>
Substance Abuse & Pregnancy	Members who are pregnant women in need of routine substance abuse services must be admitted within forty-eight (48) hours of seeking treatment.
Intravenous drug use	Members who are intravenous drug users must be admitted not later than fourteen (14) days after making the request for admission or one-hundred and twenty (120) days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not

Access to Behavioral Health Care	
	later than forty-eight (48) hours after such request.
Community Based Interventions Screening for Children/Youth Admitted to an Acute Care Facility	Within 48 Hours of Admission by Contacting the Department of Mental Health Child/Youth Care Manager
Routine Behavioral Health Appointments	Within three (3) weeks of the request for an appointment
Initial Service in the Follow-Up Care Based on Results of an Assessment	Within 10 Business Days of Completion of the Assessment
Waiting Time in a Provider Office	Not to Exceed 45 Minutes
Use of Free Interpreter Services	As Needed Upon Member Request During All Appointments

## Behavioral Health Services Requiring Prior Authorization

**For a list of services requiring prior authorization or notifications, please see Section V, Utilization Management.**

The AmeriHealth Caritas Iowa Utilization Management (UM) department hours of operation are 8 a.m. to 5:30 p.m., Monday through Friday. For prior authorization requests for behavioral health inpatient admissions, the UM department is available 24/7/365. The UM department can be reached at:

- Behavioral Health Utilization Management phone: 1-844-214-2474
- Behavioral Health Utilization Management fax: 1-844-214-2469

For the initial prior authorization of **inpatient stays, electroconvulsive**, please submit requests by telephone to the UM department. Requests are also accepted by fax if they contain all the appropriate information to support a medical necessity review and/or level of care evaluation. Requests to extend authorization on these services may also be submitted by telephone to the UM department.

For additional information on how to submit a request for prior authorization, please refer to the provider area of our website at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com).

Behavioral Health services requiring prior authorizations can be found in Section V: Utilization Management, under Behavioral Health Services requiring Prior Authorization.

## Billing for Behavioral Health Care Services

Behavioral health providers will follow the same billing procedures as medical health care providers with some exceptions. Please refer to the “Claims Submission Protocols and Standards” section of this *Provider Manual* for more information on how to submit claims for behavioral health care services covered by the Plan.

If you are accredited by the Division of MHDS as an Accredited MH or DD Provider or are deemed as an Accredited Provider you will bill using the Clinic information as both rendering and billing. You will not insert the rendering clinicians name on the claim, rather the organization NPI will be indicated in the rendering clinician block.



## Provider Manual

For more detailed billing information and line-by-line instructions, please refer to the *Claims and Billing Manual*, available in the provider area of our website at [www.amerihealthcartiasIA.com](http://www.amerihealthcartiasIA.com).

## **Section XI LTSS PROVIDERS**

## XI. LTSS Providers

### Introduction

The information contained in this section of the *Provider Manual* applies to providers who are contracted with AmeriHealth Caritas Iowa to provide covered long term services and support (LTSS) services. Please note that, in general, the responsibilities, expectations and processes outlined in this *Provider Manual* pertain to all providers, including LTSS providers, unless otherwise indicated in this section or specified via subsequent communications. For more information, please contact Provider Services at **1-844-411-0579**.

AmeriHealth Caritas Iowa shall ensure that services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS. The Iowa Department of Human Services (DHS) is dedicated to serving individuals in the communities of their choice within the resources available and to implementing the United States Supreme Court's mandate in *Olmsted v. L.C.*

AmeriHealth Caritas Iowa shall support and enhance member-centered care. When members reside in nursing facilities or Intermediate Care Facility/ Intellectual Disabilities (ICF/IDs), those facilities are primarily responsible for the care and treatment of those individuals, and for addressing health and safety needs. Members residing in these facilities receive additional care management and quality oversight from AmeriHealth Caritas Iowa. When members with health and long-term care needs live in their own homes or other community-based residential settings, AmeriHealth Caritas Iowa will develop a care plan to address their care and treatment needs, provide assurances for health and safety, and proactively addressing risks inherent in members' desire to live as independently as possible. Further, AmeriHealth Caritas Iowa LTSS providers who provide non-institutional services must offer LTSS services in settings that comport with the CMS home and community-based setting requirements as defined in regulations at 42 C.F.R. § 441.301(c)(4) and 42 C.F.R. § 441.710(a).

### Waiver & LTSS Continuity of Care

AmeriHealth Caritas Iowa shall not reduce, modify or terminate LTSS services in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. AmeriHealth Caritas Iowa shall ensure members receiving LTSS will be permitted to see all current providers on their approved service plan, when they initially enroll with AmeriHealth Caritas Iowa, even on a non-network basis, until an updated service plan is completed, either agreed upon by the member or resolved through the appeals or fair hearing process, and implemented. AmeriHealth Caritas Iowa shall honor existing exceptions to policy granted by the DHS for the scope and duration designated. AmeriHealth Caritas Iowa shall extend the authorization of LTSS from a non-contracted provider as necessary to ensure continuity of care pending the provider's contracting with AmeriHealth Caritas Iowa, or the member's transition to a contract provider. AmeriHealth Caritas Iowa shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by AmeriHealth Caritas Iowa without any disruption in services.

If a member enrolls with AmeriHealth Caritas Iowa and is already established with a provider who is not a part of the network, AmeriHealth Caritas Iowa shall make every effort to arrange for the member to continue with the same provider if the member so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network. If a LTSS provider chooses not to become part of the AmeriHealth Caritas Iowa LTSS network the member will be transitioned to an in-network provider of their choice at the end of the Continuity of Care period.

## Member Referral to the LTSS Program

The Iowa Department of Human Services (DHS) has approved the tools that AmeriHealth Caritas Iowa will use to determine the level of care and assessed supports needed for individuals wishing to access community supports. The intention of the multi-purpose evaluation is to provide uniformity and streamline the documents completed to determine the appropriate level of care and outline the assessed needs of the individual. The tool is also used to evaluate whether or not the needs are being met and the provider's ability to perform the tasks as assigned. The tools currently designated by DHS, are as follows:

Program	AIDS/HIV	Brain Injury	Elderly	Health and Disability	Intellectual Disability	Physical Disability	Children's Mental Health	Habilitation
Assessment	InterRAI-HC	InterRAI-HC	InterRAI-HC	InterRAI-HC	Supports Intensity Scale (SIS)	InterRAI-HC	InterRAI-HC	InterRAI-HC

Our Care Connector will conduct an assessment, as described, using tools and processes previously noted for members who have been identified as potentially meeting an institutional level of care for 1915(c) HCBS waiver enrollment. AmeriHealth Caritas Iowa shall refer individuals who are identified as potentially eligible for LTSS to DHS or its designee for level of care determination, if applicable. Members must apply for the waiver and be granted a waiver payment slot before any LOC reviews will be done by DHS.

If you recognize a member with a special, chronic or complex condition who may need LTSS support please contact the Rapid Response team at **1-855-332-2440, prompt #3**. Providers can also print a "Let Us Know" intervention form found at [www.amerihhealthcaritasIA.com](http://www.amerihhealthcaritasIA.com) and fax to our Rapid Response fax line at **1-844-412-7886**, and one of our care connectors will contact you.

## Credentialing LTSS Providers

The Plan credentials and recredentials providers in accordance with the National Committee for Quality Assurance (NCQA) credentialing standards and ensures that all providers, facilities and AmeriHealth Caritas Iowa who deliver LTSS meet licensing, certification and qualifications required by: Centers for Medicaid and Medicare Services, the Iowa Home and Community Based Services (HCBS) Waiver Program: Iowa Department of Human Services (DHS); Iowa Department on Aging; and the Iowa Department of Public Health (IDPH).

Practitioners/AmeriHealth Caritas Iowa/Facilities covered by this policy will be recredentialled at least every three years.

LTSS providers are required to accept the contractual terms and conditions, reimbursement terms and meets the state's and the health plan's credentialing and quality standards. AmeriHealth Caritas Iowa will maintain a network that includes LTSS providers whose physical locations and services accommodate individuals with physical, behavioral and intellectual/ developmental disabilities

Credentialing staff abide by policies and procedures for the collection, use, transmission, storage, access to and disclosure of Confidential Information in order to protect the privacy and confidentiality rights of the Plan's Members, Practitioners, AmeriHealth Caritas Iowa and Providers to ensure the appropriate and legitimate use of the information.



This applies but is not limited to the following Practitioner/AmeriHealth Caritas Iowa LTSS provider types:

## LTSS Provider Types

- Adult Day Care
- Assistive Devices
- Assisted Living
- Case Management
- Chore Services
- Consumer Directed Attendant Care (CDAC)
- Counseling Services
- Emergency Response System
- Home and Vehicle Modification
- Home Delivered Meals
- Home Health Aide
- Home Maker Services
- Nursing Services
- Nutritional Counseling
- Personal Emergency Response System (PERS)
- Respite Care
- Senior Companions
- Specialized Medical Equipment
- Supported Community Living:
- Transportation

LTSS providers will either be credentialed directly by AmeriHealth Caritas Iowa, or indirectly by delegated vendors who uphold DHS credentialing criteria.

## AmeriHealth Caritas Iowa Credentialing

All LTSS providers are required to meet the following state minimum requirements:

- Current, unrestricted state license, if entity is licensed.
- Current, active certifications, where applicable
- Current, active, unrestricted Medicaid ID number.
- Individual National Provider Identification (NPI) number and group NPI number.
- Current certificate of liability insurance.

Additionally, the AmeriHealth Caritas Iowa credentialing process will include a review of the following for each provider:

- Medicaid sanction status though OIG's List of Excluded Individuals, Entities Database and the General Services Administration
- Background checks as required by Iowa DHS

## Delegated Vendor Credentialing

- In instances where a provider is part of a delegated vendor credentialing LTSS network, AmeriHealth Caritas Iowa will rely on the credentialing methodology adopted by that organization. All LTSS providers must meet at least the minimum requirements listed above.

## Self-Directed LTSS Providers

Self-directed LTSS providers who are not employed by a provider agency or licensed/accredited by an agency/board that conducts background checks will also be subject to:

- Criminal background checks
- Child and dependent adult abuse background checks
- Licensing, certification and qualifications as set forth above.

## LTSS Provider Credentialing Rights

### Right to Review Information Submitted

LTSS providers have the right to review information submitted to support the credentialing application process with the exception of peer references and National Practitioner Data Bank (NPDB) reports. Currently AmeriHealth Caritas Iowa does not require peer references for LTSS providers. In addition non-licensed providers have the right to be notified if information received by the Credentialing Department is substantially different than was reported by the provider. The Credentialing Department will notify the provider of the information that varies substantially from what was submitted.

### Right to Correct Erroneous Information

LTSS providers have the right to correct erroneous information submitted in support of their credentialing application. Corrections must be submitted in writing to the credentialing staff within ten (10) business days of notification to the provider. Corrections or information received will be reviewed and documented in the practitioner's file.

### Right to be Informed of Application Status

LTSS providers may request information about the status of the application they submitted at any time during the process. Such requests must be made to the Credentialing Department, who will provide information about the status of the application, including whether or not it was received, whether or not it was complete upon receipt, and/or whether or not it is scheduled to be presented to the Credentialing Committee or Medical Director for review, etc.

## LTSS Provider Application Process

### Individual Provider Application

The application process for individual LTSS providers requires the submission of a completed application. The application must include the following:

1. LTSS Credentialing Application
2. Current, unrestricted State License (if applicable)
3. Current State Certification/accreditation (if applicable)
4. State bond (if applicable)
5. CV/Resume (if applicable)
6. Current Insurance liability policy (showing expiration and times)
7. Explanation of affirmative answers on the application

To obtain a LTSS application, please visit the AmeriHealth Caritas Iowa website [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com) or contact your account executive.

### **Credentialing Committee/Medical Director Decision**

AmeriHealth Caritas Iowa does not make credentialing/re-credentialing decisions based on the applicants' race, ethnic/national identity, gender, age, sexual orientation, the types of procedures in which the practitioner specializes or the patients for which the practitioner provides care. In developing its network, AmeriHealth Caritas Iowa strives to meet the cultural and special needs of members.

Applicants are notified of their initial credentialing approval within 60 calendar days of the Credentialing Committee's recommendation. Should the Credentialing Committee elect to decline participation, the applicant will receive a detailed explanation and be offered the opportunity to review documentation used to make the decision (with the exception of NPDB reports and peer references).

### **Re-credentialing**

Re-credentialing involves periodic review and re-verification of clinical credentials of network providers. The Credentialing database houses all LTSS provider information and a report is run to ensure each provider organization, facility and individual LTSS provider is re-credentialed as scheduled. As part of this process, AmeriHealth Caritas Iowa periodically reviews provider information from the National Practitioner's Data Bank (NPDB) as well as the Office of Inspector General list of individuals who have been excluded from participation in Medicare and Medical Assistance Programs. Providers are required to disclose, at the time of discovery, any criminal convictions of staff members related to the delivery of health care or services under the Medicare, Medicaid, or Title XX Social Service programs. Such information must also be reported at the time of application for or renewal of network participation (Credentialing and Re-Credentialing). Providers are also obligated to provide such information to AmeriHealth Caritas Iowa at any time upon request.

The re-credentialing process occurs at least every three years. The re-credentialing process includes an up-to-date re-examination of all the materials and a review of the following:

- Member complaints and grievances
- Results of quality indicators monitoring and evaluating activities
- Re-verification of licensure standing
- Re-verification of Certifications
- Sanction history

### **Address Changes**

As a reminder, providers are contractually bound to report changes that affect referrals, such as the relocation of an office site. If your office is considered high volume, relocation of your office site will require a site visit from AmeriHealth Caritas Iowa.

## **Contracting and Rate Notices**

### **Contracts**

To support LTSS providers, AmeriHealth Caritas Iowa uses an Ancillary Provider Agreement that is approved by all the appropriate local authorities. Provider Agreements automatically renew each year. An amendment to the agreement will be generated only if new services are added due to a change in the state Medicaid program. Rate Notices are used to document rate or per diem changes to existing services.

### **Rate Notices and Fee Schedules**

The fee schedule is reviewed regularly and rates are adjusted as necessary. As a network provider, you will occasionally receive a "Rate Notice" which is an official amendment to the Provider Agreement.

Providers will receive 30 days' notice of rate changes. Providers who do not accept the terms of the Rate Notice may terminate the agreement upon 30 days' written notice.

Please review EOB's closely to assure that you begin receiving the new rates for services delivered on or after the date indicated upon notice of an updated fee schedule. You are responsible to monitor payment received from the Plan. In the event of a discrepancy, please contact your Account Executive immediately. AmeriHealth Caritas Iowa strongly suggests provider's bill the usual and customary charges rather than the rate indicated on the Rate Notice. In the event of a system or data entry error, this practice will help you avoid the need to resubmit corrected claims when the issue is resolved.

## LTSS Covered Services

See Section III, "Provision of Services" under 1915 (c) and 1915 (i) Waiver Services for covered benefits. For the most comprehensive and current information on LTSS, reference the Iowa HCBS provider manual at: <https://dhs.iowa.gov/sites/default/files/HCBS.pdf>

## Access to LTSS Care

AmeriHealth Caritas Iowa and LTSS providers must meet standard guidelines as outlined in this publication to help ensure that Plan members have timely access to LTSS care.

The Plan endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. AmeriHealth Caritas Iowa and establish mechanisms for measuring compliance with existing standards and identifying opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for members should comply with the access standards defined below.

The standards below apply to; LTSS providers please refer to the "Provider and Network Information" section of this *Provider Manual* for the standards that apply to health care services and medical providers

LTSS Access Standards	
Institutional Providers	All licensed and Medicaid certified Nursing Facilities and ICF/IDs will be offered inclusion in the AmeriHealth Caritas Iowa provider network for two (2) years. Following the minimum period, the plan will evaluate each facilities continued network enrollment based on assessment of quality and performance outcomes.
HCBS Providers	HCBS Providers must be within 30 minutes or 30 miles from members in urban counties and 60 minutes or 60 miles from members in rural counties Two (2) providers per county for each HCBS covered in the benefit package for each 1915 (c) HCBS waiver. In the event a county has an insufficient number of providers licensed, certified or available, the access standard shall be based on the community standard and will be documented to the Iowa DHS.

LTSS Access Standards	
Non-Network Providers	In the event that participating provider cannot meet program standards, AmeriHealth Caritas Iowa will extend authorization of long term care services to an out-of-network provider to ensure continuity of care
Distance	Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed twenty miles for members in urban areas, not to exceed thirty (30) miles for members in suburban areas and not to exceed (60) miles for members in rural areas where community standards and documentation apply.

### LTSS Services Requiring Prior Authorization

LTSS services requiring prior authorizations can be found in Section V:Utilization Management, under **LTSS Services requiring Prior Authorization.**

**To determine if a service requires prior authorization, call Utilization Management at:** Phone: 1-844-411-0604, or fax your requests to: 1-844-211-0972. The Utilization department hours of operation are 8 a.m. to 5:30 p.m., Monday through Friday.

After hours, call the Nurse Call Line at: **1-855-216-6065.**

### Billing for LTSS Providers.

LTSS providers will follow the same billing procedures as medical health care providers. Please refer to the “Claims Submission Protocols and Standards” section of this *Provider Manual* for more information on how to submit claims for LTSS care services covered by the Plan.

For more detailed billing information and line-by-line instructions, please refer to the *Claims and Billing Manual*, available in the provider area of our website at [www.amerihealthcaritasIA.com](http://www.amerihealthcaritasIA.com).

### LTSS Provider Contract Terminations

AmeriHealth Caritas Iowa Agreements specify termination provisions that comply with the Iowa Medicaid Enterprise (IME) requirements.

Either AmeriHealth Caritas or the provider may terminate the Provider Agreement at any time with at least sixty (60) days prior written notice of the intention to terminate the Provider Agreement. If the provider is a group, either AmeriHealth Caritas Iowa or the provider may terminate the Provider Agreement at any time with at least ninety (90) days prior written notice.

The effective date of termination will be on the first of the month following the expiration of the notice period. Termination of the Provider Agreement for any reason, including without limitation the insolvency of AmeriHealth Caritas Iowa does not release the provider from his or her obligations to serve members when continuation of a member’s treatment is medically necessary.

Notwithstanding the above, AmeriHealth Caritas Iowa may terminate the Provider Agreement immediately in the event any of the following occur:

- If the provider (or, if the provider is a group, any group practitioner) or a person with an ownership or control interest in the provider is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program under Section 1128 or 1128A of the Social Security Act or any other federal health care program.
- If the provider (or, if the provider is a group, any group practitioner) is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.
- If the provider (or, if the provider is a group, any group practitioner) is convicted of any felony or of any crime related to the practice of medicine.
- Upon the loss or suspension of the provider's professional liability coverage.
- The suspension or revocation of the provider's license or other certification or authorization necessary for the provider to render covered services, or upon AmeriHealth Caritas Iowa reasonable determination that the health, safety or welfare of any member may be in jeopardy if the Provider Agreement is not terminated.
- If the provider (or, if the provider is a group, any group practitioner) fails to satisfy any or all of the credentialing requirements of AmeriHealth Caritas Iowa or fails to cooperate with or abide by the Quality Management Program.
- If the provider (or, if the provider is a group, any group practitioner) breaches a material provision of the Provider Agreement or is engaged in any conduct which would injure the business of AmeriHealth Caritas Iowa.

To the extent the provider is a participating physician, if AmeriHealth Caritas Iowa decides to suspend or terminate the Provider Agreement, AmeriHealth Caritas Iowa shall give the provider written notice, to the extent required by the Iowa Medicaid Enterprise of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate the provider and the numbers and mix of providers, AmeriHealth Caritas Iowa needs. Such written notice shall also include the provider's right to appeal the action and the process and timing for requesting a hearing.

Upon termination of the Provider Agreement for any reason, AmeriHealth Caritas Iowa shall notify affected members of the termination of the provider (or, if the provider is a group, any group practitioner) in accordance with the notification requirements under 42 C.F.R. §422.111(e).

AmeriHealth Caritas Iowa will notify members and begin the transition process from a provider who notifies members of termination upon receipt of the notice from the provider. Providers who are providing LTSS services to members will be required to maintain services to the member in accordance with the member's plan of care until the member has been transitioned to a new provider, as directed by AmeriHealth Caritas Iowa, which may exceed the thirty (30) days from the date of notice from the date of notice to the plan.

## LTSS Provider Standards

AmeriHealth Caritas Iowa's LTSS providers are held to the same as all other AmeriHealth Caritas Iowa providers. All LTSS providers should review all sections of the manual to ensure that they are compliant with quality standards, cultural competency requirements and more. The LTSS section of the AmeriHealth Caritas Iowa manual covers items that are specific to the LTSS provider but does not preclude them from the standards and requirements through the AmeriHealth Caritas Iowa provider manual.

## Appendices





**Appendix A – Advance Directive**

**Appendix B – IDPH – Table of Reportable Communicable and Infections Diseases**